A Comparison of the Policies and Methodologies Adhered to by Drug Treatment Centres in Christchurch, Aotearoa.

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Preface

Addiction is one of this society's rapidly growing social problems. Every time an addict imbibes and abuses a substance, which enhances their dependence and promotes antisocial behaviour, the effect on society is damaging and expansive. Social services such as medical professionals, the police, members of Government agencies, and regional public servants, in addition to family, extended or immediate, friends or acquaintances, employers and work associates, usually suffer to some degree through contact with a dependent addict. By extension then, every taxpayer incurs a financial penalty every time a "using" drug dependent addict interacts with other members of this society.

Addicts come from all walks of life and present at health providers with multifaceted, interrelated dependence issues. Professionals who treat addicts need all the support society can provide. Until the middle of the last century, however, addiction was not even recognised as a distinct clinical phenomenon (Mattick, 1992). Currently, there is a paucity of information about drug dependence and its treatment not only in Aotearoa, but around the world. Consequently, professionals cannot search for relevant literature because the available information is scant, not related or absent.

Primary, Secondary and Tertiary addiction treatment centres are islands of sanctuary where addicts can seek treatment for at times life-threatening maladaptive behaviours associated with substance abuse and dependence. The distinctions between these three different forms of early treatment are discussed in this thesis, and the delineation between abuse and dependence is outlined in the definitional section in Chapter 2. That addicts require safe haven has only recently been recognised and thus, substance dependent people have limited options when seeking treatment. The scarcity of treatment options is a direct reflection of the dearth of data about addiction. This does not bode well for either current or future addicts, or people who treat or will provide health care for them.

Addiction professionals play a pivotal role in offering treatment to those who would otherwise have nowhere to turn. These men and women who have chosen to help others with drug dependence issues are some of the most important health care providers in the medical domain and require all the assistance that society can offer.

Unfortunately, as will be seen in this thesis, this support is scarce and extremely volatile, depending on the understanding of the public and the contemporary economic environment. This is an untenable situation, because for every addict who continues to exhibit maladaptive behaviours in the cyclic, self-perpetuating dependence pattern. Like a stone thrown into a pond, in time the ripples affect an exponentially increasing number of people in society.

Acknowledgements

Many people, professional and otherwise, helped in the production of this thesis. Anonymity is one of the crucial criteria of consent for an interview and all of the participants will, consequently, remain anonymous. Amongst the other sources of information, inspiration and motivation, exist members of the addict community, many of whom are my friends and shall also remain anonymous. This is in keeping with the moral and ethical principles of this research process, the guidelines presented by the Ethics Committee, and one of the traditions of the twelve-step recovery programmes such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). In fact, the only information that should ever leave a meeting of twelve-step addicts, is the message of recovery.

A special thank you goes to the seven interview participants who took time out from their hectic schedules to help a student obtain a clearer picture of the multifaceted malady of addiction treatment in Canterbury. In many ways it is a pity the information providers cannot be named because they are worthy of all the recognition, acknowledgement and support they deserve. The seven health care providers, together with a limited number of other professionals, perform one of the most difficult jobs in this society. The treatment of addicts involves working with people who are experiencing an emotional roller coaster that has antecedents, reinforcements and behaviour usually exhibited and experienced in the extreme. Therefore, working with addicts and their need to be treated, is an occupation that is certainly not suitable to just anyone. It takes very special people to work in the field of addiction. Without these seven frontline heroes in the fight against addiction, this thesis would simply not have been possible.

Distinguished credit is also due to two angelic women, Sandra Kirby and Debra Long, working in the office at the Alcohol Advisory Council of Aotearoa (ALAC), in Christchurch. An anonymous ALAC staff member, visiting from an unknown location, who offered a last-minute contribution worth its weight in gold, is another person who assisted the researcher in his darkest hour with her brilliant expertise. The preparation, integration and eventual production of this thesis would have been incredibly difficult without their assistance and support, which they gave freely and without restriction.

I would like to offer my gratitude and appreciation to Dr. Arnold Parr and Dr. Bob Hall, my primary and secondary supervisors. Their patience, understanding, assistance and

guidance were invaluable and I will always be eternally grateful. Finally, but certainly not least, a big thank you to Sam Will, who spent many hours editing this thesis.

Ultimately, this thesis is dedicated to everyone who supports the fight against drug abuse and dependence, in addiction's vast array of potential disguises. It is hoped that the suggestions presented here are discussed and implemented in the near future, thereby reducing and alleviating potential harm or possibly averting impending death. Addiction, like a canker if left unchecked, consumes everything in its path to the detriment of the addict and society.

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Abstract

This thesis examines the current polices and methodologies used and promoted by drug treatment centres in Christchurch. Personal experience and the subsequent awareness of the need for more available literature developed into the motivation for this thesis. Deficiency in knowledge about the current status of treatment demands clarification of the options which an addict may avail for his or her self in order to change the destructive cyclic pattern of maladaptive behaviours which reduces life's enjoyment and in some cases results in death.

The hypothesis, therefore, was that if more pertinent literature were obtainable, then the suffering of addicts in the wrong treatment or simply not seeking any help at all, may be reduced. In due course, perhaps an addict may change her or his life by seeking help from the correct health provider, guided by the information presented here. The overarching objective of this thesis is the clarification of treatment possibilities and contributing to the public awareness, thereby reducing actual and potential anguish or distress.

Seven addiction professionals participated in interviews and were asked about their respective agency's treatment policies and methodologies. Two programmes declined to take part and subsequently lessened the reliability and validity of this study. The flexibility built into the research design was also not enough to cope with reality. The information obtained from the interviews, however, was sufficient to offer a strong indication for future directions in the field of addiction treatment.

The results are compared both with each other and with data gathered during the literature review, which indicates that key issues experienced internationally are mirrored in Canterbury. Furthermore, there is not enough existing data or resource allocation for the treatment of present addicts, which is compounded by recent escalating trends in drug consumption. Contemporary Aotearoa is becoming ever more diverse with increasing numbers of immigrants from all over the world. Diaspora in post-modernity is a consequence of globalisation and the reduction of space and time (Giddens, 1997) which is, economic factors permitting, constantly gathering momentum. This diversity is reflected in the addict population, but not in mainstream health care providers.

An outcome of this thesis is the call for more specific drug treatment centres that cater to subgroups of addicts who currently have nowhere to turn for help. The conclusion is a plea for immediate action to avert disastrous consequences in the near future for addicts, their families and the general public in Christchurch, and in Aotearoa as a young nation.

Chapter 1

Introduction

Addiction in the Past

The use of substances for various reasons such as recreation or during social rituals or traditions is not a recent phenomenon. "Humans were apparently familiar with beer, wine, and mead dating back at least to Palaeolithic times....References to the recreational use of alcohol appear in the Old Testament, Mesopotomanian sayings, and Egyptian hieroglyphics" (Goodwin & Guze, 1989; p.142). Concentrating alcohol by distillation was invented in AD800, but, interestingly, it was not until 1848, that Magnus Huss coined the label alcoholism (Goodwin & Guze, 1989). Individuals who experienced abuse problems with alcohol or other psychoactive substances, who today could be classified as addicts, would presumably have fitted into other stigmatised categories in the past, such as demented, possessed, outcast, or even criminal (Goffman, 1986).

Imbibing substances to reduce physical pain, induce relaxation or promote pleasant mind-altering conscious states has existed as far back as prehistoric times. "Almost all peoples have discovered some intoxicant that affects the central nerve system, relieving physical and mental anguish or producing euphoria" (Neale, 1994; p.286). The use of such substances is not new and yet the treatment of individuals with substance dependence issues is in its infancy.

In the 1970's, here in Christchurch, alcoholics presenting for help and treatment were stereotypically diagnosed (psychiatric/psychological disorder), regimentally treated in archaic centres staffed by people who viewed patients as extremely problematic at best (draconian therapy administered by ignorant professionals), and forced to comply with regulations and submit to treatment (MacEwan, 1997). Clients presenting with varied drug addictions, or those now known as polyaddicts, who use multiple concurrent substances, had not yet arrived in large numbers and the treatments on offer came straight from the dark ages. Change has occurred in both sides of the therapeutic dynamic between addict and health care provider.

The central topic of this thesis, however, is not a discussion of historical drug abuse or dependence, nor the treatment options offered in the past by our society or any other.

The past is mentioned to clarify that addiction is not a relatively new phenomenon. Health care professionals in the domain of addiction treatment in our society cannot, however, avail themselves of a rich informative database offering clear guidelines into the multifaceted areas of this maladaptive behaviour and its repercussions. The current knowledge Western society has regarding addiction is outlined in Chapter 2. The implications and consequences of the paucity of information are discussed throughout the thesis.

The World We Live In

Capitalist Westernised countries, such as the United States, Canada, Australia and Aotearoa, and larger areas such as the European Continent and the United Kingdom, all heavily promote the consumption of multiple drugs through advertising, norms and mores. Many people use drugs "on awakening (coffee or tea), throughout the day (cigarettes, certain soft drinks), as a way to relax (alcohol) and means to reduce pain (aspirin)" (Neale, 1994; p.286). "Being allowed to smoke cigarettes or drink alcohol at home is viewed as the hallmark of maturity by many contemporary teenagers in Australia...Aotearoa...and the United States" (Peterson, 1989; p.385). Children use parents as role models and assume frequently repeated parental behaviours are normal and acceptable.

This endemic use of substances sets the social stage, or promotes individual reliance on, abuse and dependence on mind-altering chemicals. Much of daily life involves routines and chores which encourage individuals who find them monotonous to find ways of coping by changing their psychological states, thereby experiencing an alleviation or escape from monotony (Cohen & Taylor, 1992). Drugs such as coffee and cigarettes produce mild effects that alleviate or change the perceptions of individuals performing chores and routines, reducing distress and elevating potential task completion.

Drug addiction is pandemic in nature and ubiquitous in scope. It is "one of the most serious problems that our species presently faces" (Carlson, 1994; p.582). Drugs produce or are associated with a plethora of medical ailments and potentially may even cause death. The abuse of substances places strain upon every societal institution in

this culture, such as health, medical, legal, political, economic and religious (Muchinsky, 1993). Moreover, polyaddiction may cause synergy (Neale, 1994), which promotes or increases the potential affects of the imbibed drugs due to the reactions on each other in the body. Drugs affect multiple organs in a user's body and some substances change the perception of time (Schiffman, 1990).

All the drugs taken in our society stimulate the production of dopamine in the nucleus accumbens and thus, reinforce the antecedent behaviours with pleasant experiences. Substances may be swallowed, smoked, sniffed, injected or absorbed into the bloodstream when inserted into a bodily orifice (Carlson, 1994). By definition the addictive substances that stimulate dopamine cross both the blood-brain barrier and the placenta. This occurs because psychoactive substances are fat-soluble and carried through the body in the blood-stream. We are not the only species to consume drugs. Animals freely ingesting addictive substances also manifest dependent drug taking addiction cycles, consequently exhibiting maladaptive behaviour.

One of the reasons treatment of addiction has been hampered is the reliance on assumptions adhered to by the majority of health care providers, as evidenced by recent literature. It has become apparent that most professionals in the domain of addiction espouse myths about the treatment of people with substance dependence issues. For example, a clinician argues:

- We assume that addiction is uncommon, yet one in three patients seen in primary care has a substance abuse disorder, most commonly due to problems with alcohol, tobacco, or prescribed medications.
- We assume that the natural history of addiction is progressive. Patients eventually "hit bottom," then recover and stay "dry." In fact, for most patients the road is complex, marked by periods of problem use, abstinence, recovery, relapse, and controlled use.
- We assume that the specific addictive substance is essential in understanding a patient's problem; however, many patients use multiple substances. Furthermore, there are great similarities between "addictive personalities," regardless of the chosen substance of abuse.

- We assume that it is solely the patient's responsibility to gain control over the addiction. In fact, both the physician and the patient's family can play important roles in identifying the problem and supporting the patient's efforts to solve it.
- We assume that the quantity of the substance (e.g., alcohol, benzodiazepines, tobacco) correlates well with the level of (the) patient's problem. In fact, there is wide variation between the quantity consumed and the degree of disruption in a person's life.
- We assume that all of a patient's problems can be traced to addiction when at least one problem is addiction. In fact, substance abuse is often intertwined with other prior psychiatric illnesses.
- We assume that addiction is easy to recognize. In fact, in most patients the problem goes undiagnosed, for example, the hypertensive patient whose blood pressure cannot be controlled because of alcohol, the patient with peptic ulcer who does not respond to H2 blockade because of continued smoking, or the adolescent who is failing school and heavily using marijuana. (Fischer, 1992; p.xi).

Grouping together such a dangerous list of assumptions when treating a potentially life-threatening malady poses frightening possibilities for current addicts. There is, however, a problem with Fischer's oversimplification of the facts. Throughout the quote he alludes to the intertwining of problems with psychological illnesses, but does not discuss the potential scope or range of the implications. Addiction may be entangled with many other facets of a client's life apart from psychiatric illnesses. Addiction can influence and effect every aspect of an addict's life from dreaming to each daily interaction. In addition, although there are many similarities between addicts there are also many unique individual differences.

"Not everyone is equally likely to become addicted to a drug" (Carlson, 1994; p.590). Many people use drugs in purely recreational situations and others may abuse substances on a regular basis but do not become addicts. Twin and cross-fostering studies indicate that there is a genetic component to addiction susceptibility (Carlson, 1994). It is established that heredity does contribute to the potential development of addictive behaviour and that an individual's environment is also influential. It is also well

known in the scientific community that we really know very little about the spectrum of addiction, but that the need for further research is growing at an exponential rate.

A Societal Snapshot of Addiction Treatment

The pace of change in the field of addiction is gathering momentum. As facets of the malady have become clearer to health care providers, researchers and society, and the scope of its effects increasingly felt in all centres of Aotearoa, so the call for improved understanding and efforts to establish a definitive picture has become stronger. This entails more effective diagnosis, screening, assessment, treatment matching and treatment with unimpeded goal establishment and outcome maintenance. Understanding where professionals in the domain can and should concentrate their energy is tantamount to improving the services available to addicts.

For numerous people the cessation of addictive substance consumption is not the hardest part of establishing and maintaining a successful lifestyle free from maladaptive dependent cyclic behaviours. Achieving a beneficial long-term outcome of positive behavioural reduction or termination of the ingestion of mind-altering substances, and the dependence upon them, requires behavioural modification. Research suggests that behavioural modification techniques can help to increase the chances of a person improving their lifestyle without depending on drugs to alleviate distress (Sarafino, 1996).

How people receive or engage in these behavioural modifying techniques is another central theme of this thesis. The rapid pace of change in the addiction domain, however, will render this thesis obsolete relatively recently after its production. Therefore, the results of this investigation provide only a brief picture of germane facets and the central arena of addiction treatment in Aotearoa.

The Goal of this Thesis

The primary argument is that a clear picture, albeit momentarily, can be established of the treatment offered in Canterbury. This can be achieved by comparing the results of information obtained from interviews with health care providers (professionals in the

treatment of addiction) regarding the consequential associated maladies of addiction. By supplying a descriptive analysis and comparison of the policies and methodologies used by programmes in this area, readers, if requiring treatment, can avail themselves of the information presented here to improve their chances of matching themselves to specific requirements.

In addition, the snapshot should also indicate the central themes of addiction which, if sufficiently explored, could serve as a potential contribution to the call for improvements. Currently there are many ambiguities associated with addiction and its treatment. A comparison with similar Westernised societies as well as treatment policies and methodologies adhered to by minority cultures may identify and promote directions for future research.

The Scope of this Thesis

The following chapter begins with the identification of addiction, addicts, clarification of abuse and dependence, and offers a sociological interpretation of the current societal situation. After a presentation of the highlights discussed in the international literature and comparison with data from Aotearoa, the term medicalisation is explored. This leads into addiction treatment, assessment, co-morbidity issues and non-researched treatments. Addiction is a reflection of the wider society and like the general population contains many subgroups. These subgroups may be categorised by differences in cultural, gender, age, and sexual orientation.

Chapter 3 begins with a brief discussion regarding ethics and morality and how these influence research behaviour and guidelines. This flows into theory construction and the formulation of the hypothesis for this thesis. The discussion then moves into validity and reliability and how these affect the questions that will be posed during the interviews. Sample identification and access is presented before an outline is given of the material contained in the letter of introduction, which was sent to all of the potential interview participants. The prospective differences between interviewee and questioner are explored and various aspects, which might affect the data gathering process, are discussed. Possible biases are presented and the chapter concludes with brief outlines of the equipment and data correlation.

Chapter 4 conveys the actual process from obtaining the directory of current treatment programmes to selection criteria and identifying the representative sample. The reactions to the letter of introduction are followed by a description of the first contact. The bulk of the chapter then discusses the interviews and what occurred while the information was being obtained. There are seven interviews and the degree of flexibility incorporated in the research design and the actual consequences are outlined in the latter stages of this chapter.

The following chapter offers the results of the interviews. This begins with a comparison of the client assessment and treatment matching which is vital to establishing the relationship between addicts and health providers. The inherent differences in the population of addicts, as outlined in Chapter 2, are each discussed by comparison with the information obtained from the participants. The next section outlines some of the primary changing facets of addiction treatment, such as different concepts of health and the vying for limited resources which may encourage competition and reduce co-operation between the treatment facilities.

The last chapter is split into three main sections. The first of these outlines methodological issues that arose during the interviews, and revisits the validity and reliability of this thesis. The second part of the chapter discusses the central themes reoccurring throughout the thesis such as funding, research and treatment models and specificity. It also addresses the knowledge of the general public and addicts regarding addiction. The last part presents the paradoxes inherent in addiction that need to be remedied in order to increase the potential for successful treatment, goal identification and maintenance.

It is important to retain these paradoxes in memory and revisit them as this thesis unfolds because answering and rectifying these issues will ultimately help to save lives. These paradoxes are:

1. The repeated references in the literature and actual separation of addicts according to their substance of choice. For example, alcoholics and addicts.

2. That treatment is better than none, but less than one in five addicts request it from recognised health providers.

3. That addiction has been present throughout our history but its treatment is in its infancy.

4. That increasing competition for limited resources and funding reduces co-operation between treatment centres and addiction professionals.

5. That there is for many reasons an increase in the number of multiple diagnosis clients who require more intensive assessment and treatment, but funding and resource allocation is not increasing at an appropriate level.

6. That currently there is a difference between the professionals who advocate abstinence and those who advise clients to control their drug use. This also entails adherence to or advocating the harm minimisation model that is, ironically, supported by both groups of professionals.

Chapter 2

Literature Review

Introduction

Addiction is not a new social phenomenon. It has been recorded throughout our history. One would reasonably expect then, that there would be a substantial amount of available data regarding this malady. That is, considering the numbers of people who must have presented to health care providers concerning substance abuse and dependence, surely experts would have documented their findings and discussed results of different treatment methods with each other. This is not what happened. Addicts have instead been classified according to their social status: the social elite were cured or ignored, while the lower classes were perceived to be suffering from psychological instability, labelled mentally retarded or deficient and as having low moral and disciplinary qualities, similar to deviants and criminals, and were "treated" accordingly.

In this chapter the main focus is the relevant literature available to people involved in the field of addiction. The amount of data has a direct correlation with the number of treatment programmes, the underlying philosophies and the policies and methodologies adhered to by staff in contemporary health care facilities. Every day the number of people with substance dependence issues and related maladaptive behaviour, a frequent consequence of addiction, increases. The amount of available literature, both national and international, should be growing as quickly or faster than the number of clients and facilities.

This section is a literature review of the interrelated aspects of addiction which, reflecting the domain, are broad in scope and material. Addiction and its treatment is a health issue which has had and will always have many influential aspects such as moral, legal, political, educational, emotional, psychological and sociological antecedents, implications and repercussions. The topics presented in this chapter range from societal health issues and minority group affiliations to individual identification and sexual orientation. Identifying, assessing and treating addiction covers all these societal issues because its causes and effects are now more than ever global in scope. It has in all probability affected every Westernised citizen's life to some extent.

Topic Identification and Boundary Outlines

This is a study about the philosophies, policies and methodologies used by particular treatment centres offering their services to people seeking help surmounting dependence problems associated with drugs and alcohol in Canterbury, Aotearoa. Some of these programmes also care for or treat court referrals, though the courts tend to send offenders to relevant facilities. A young offender, for example, with substance dependence issues, which are usually identified and classified by probation officers, will be placed into a youth programme. A court referral is a person who, for whatever reason, has been ordered to attend a treatment centre. Usually for a period of time suggested as sufficient stay for treatment purposes. If the individual leaves prematurely then they will find themselves once more before the legal system.

Only treatment programmes recognised by qualified professionals and researchers in the arena of addiction health care will be discussed in this thesis. However, it must be noted that there are many more different philosophies, treatments and regimes offered by various individuals and groups to people requiring help with psychoactive substance abuse and dependence. The distinction between abuse and dependence is outlined shortly. Later, non-researched policies and practices will also be mentioned.

To establish a mutually recognised point of departure is essential for any journey, literal or otherwise, and before progressing onwards there are definitional issues concerning addiction that require clarification. Researchers tend to use various labels to describe members of a certain group of people as having alcohol and drug related problems. They may be referred to as drug and alcohol dependent people; experiencing mild, moderate to severe problematic use; those who abuse licit and illicit psychotropic substances; and addicted individuals or addicts, to name a few examples (Flemming & Barry, 1992).

For the remainder of this thesis, individuals who consume psychoactive substances and develop a dependence upon them and experience problems because of their maladaptive behaviours will be referred to as addicts. Thus, in this context, an addict is a person for whom dependence upon psychotropic substances has resulted in issues that require a change in their behaviour so that they may become happier in and with their

life. Alcohol is a psychoactive substance and an alcoholic in this interpretation is, therefore, an addict.

Addicts are perceived to suffer from this disorder for the remainder of their lives and therefore any terminology that describes the malady as being in the past tense is thought to be incorrect. Instead, drug dependence in remission, recovering in comparison to recovered, are terms favoured by present clinicians (Flemming & Barry, 1992).

Definitional Aspects

Who, then, is an addict and how are they addicted? In order to clarify this question criteria may be found in the *Diagnostic Statistical Manual of Mental Disorders*, revised edition, number 4 (DSM-IV), and the *International Classification of Diseases*, revised edition number 9 (ICD-9). To gain a better insight into how the contributors to the DSM-IV established their criteria for addiction, which is the primary definitional guide for addiction in this thesis, the DSM-IV Source Book, volume 1, pages 39 to 40, is suggested reading (Widger *et al.* 1993).

A Brief Summary of the Definition of Abuse

The diagnostic model for an individual exhibiting the symptoms of abuse of psychoactive substances is listed in three options defined by criteria which the contributors obtained from the DSM-III-R (R is revised). The different options contain descriptions of symptoms indicating a maladaptive cyclic pattern of substance abuse. The health professionals list criteria such as:

- Level of affect according to threshold
- Amount of time spent intoxicated
- Antecedents and consequences
- Efforts to obtain more of the substance(s) and

- The overarching impact upon the individual's life and their social environment, such as immediate and extended family, relatives, friends and work associates.

"The essential feature of substance abuse is the maladaptive pattern of substance use manifested by the recurrent and significant adverse consequences related to the repeated use of substances" (First *et al.* 1994; p.182). In addition, on pages 182 and 183, the contributors to the DSM-IV list the symptoms of substance abuse. Sub-categories comprise a time scale, a level or amount aspect, and potential consequences of the substance abuse. It must be remembered, however, that substance abuse is different from substance dependence. A person may abuse substances on a regular basis, but this does not necessarily mean that they are dependent or, therefore, addicts.

A Brief Summary of the Definition of Dependence

In the model for dependence there are two major categories: The first is psychological and the second is physiological dependence. The label physiological dependence may be used only when an individual exhibits evidence of withdrawal or tolerance. Conversely, psychological dependence is said to be present when an individual compulsively uses the substance and exhibits behaviour that forms a usually maladaptive cyclic pattern. For a more concise description of the criteria for substance dependence, the list on page 181 of the DSM-IV specifies who may or may not be labelled a psychoactive dependent addict. However, if a person is labelled an addict, this does not necessarily mean that they are addicted. Individuals may meet the criteria, but not be addicts (MacEwan, 1999).

This thesis, which describes and contrasts the policies underpinning some of the drug and alcohol treatment facilities in Canterbury, assumes that these public services treat individuals exhibiting dependence upon psychoactive substances. For the remainder of this thesis these individuals will be referred to as addicts regardless of the substance(s) they are dependent on and abuse in maladaptive cyclic patterns. As noted earlier, some of the health care providers treat clients who, even though labelled addicts, will not actually be addicted to or dependent upon one or more substances. In addition, although for treatment purposes it becomes relevant if the client is present voluntarily or there by

court order or is an addict or not, it does not change the fact that they are clients and therefore receiving the services provided by the centre.

The International Literature

The majority of the Western world's health professionals are ill-equipped to deal with addicts and their families (Galanter, 1993). Individuals request help from professionals in positions of authority and often encounter inadequate assessment, deficient counselling and discover that they were wrong in seeking help or treatment from certain health care providers or centres. Moreover, it has been accepted by researchers in the field of addiction that many addicts have great difficulty in initially seeking any help at all (Tucker, 1995). Estimates place the percentage of addicts who request assistance at under one-fifth of the addicted population (MacEwan, 1999). Considering the correlation with addiction and maladaptive or anti-social behaviours, this has enormous implications for the wider society in which the addicts maintain their lifestyles.

It is apparent that there is a growing need for further research into this area. The majority of epidemiological studies indicate that consumption of addictive drugs, both licit and illicit, continues to increase, and that first abuse of these drugs is occurring at an ever younger age (Peterson, 1989). Early substance abuse could lessen the chances of remedial education for the young in later life. The younger the abuser the more chances he or she has of continuing the maladaptive behaviour and eventually fulfilling the criteria for dependence, although many merely experiment and develop moderate patterns of consumption (Flynn, 1992). Western society is facing a growing dilemma with enigmatic boundaries, antecedents and proportions. There are more people using psychotropic substances at younger ages, and there seems to be a fragmented series of services available to prospective clients seeking help to overcome dependence problems.

Treatment for substance abuse and the plethora of associated generic problems is, however, better then none. "Treatment for alcohol and drug problems as a whole produces net gains for the health care system and is, therefore, a worthwhile and efficient use of financial resources" (MacEwan, 1999; p.7). Research suggests that there are substantial savings for any society if it helps its addicted members (Davis & Dew,

1999; Galanter, 1999; & Raistrick, 1999). The wider sociological implications of substance dependence are discussed in the sociological section. It could be argued that it is every citizen's right to expect and receive help in the treatment of addiction issues and that it behoves society to supply it. This is an aspect of the biopsychological approach, which will be outlined shortly. Treating addicts in therapeutic settings will lower the funds spent on resources in the justice and health systems, decrease the demands placed on society in the social care environment and produce positive gains for employers, friends, relatives and, of course, the addicts themselves (Adamson, 1997).

The number of people with a dependence upon psychotropic substances is growing but there is a lack of specific research from which to discern future directions for Western society. Throughout the last century treatment providers have primarily used the guidelines presented by medical professionals, and their emphasis upon the biopsychological model has resulted in assessment and treatment deficiencies for addicts, particularly those in minority groups. One of the core concerns raised by contributors of international literature is the lack of a holistic approach, and another central issue is the meagre amount of data regarding treatment of members of sub-groups in the addicted population.

Literature in Aotearoa

We live in a rapidly restructuring capitalistic, Westernised society, which has recently seen the reduction of the welfare state in Aotearoa (Armstrong, 1990). The growing emphasis placed on viability has affected all the services available to citizens of Aotearoa to some extent. Medical help is at times withheld for various reasons such as lack of resources, funding, facilities or qualified professionals. In addition, most of the treatment centres and programmes in Aotearoa seem to operate in the biopsychological approach which focuses on changing the cognitive schema of the individual (MacEwan, 1999). The inherent deficiencies of this approach are outlined shortly.

This treatment of addicts is a consequential facet of the extended medicalisation of everyday life. The term medicalisation is discussed in the section titled "A Sociological Perspective on Addiction." This emphasis on the biopsychological model by the

European majority in Aotearoa has resulted in members of minorities forming new treatment centres for individuals of different cultures with a greater emphasis on identification, holistic treatment and client centred healing. The ideologies underlying these new facilities, the antecedents, implications and outcomes, are discussed in the appropriate sections.

A recent approach to the treatment of addiction incorporates the biopsychological approach but continues further to provide a comprehensive holistic assessment, client treatment matching, treatment and goal agenda. The newer socioenvironmental concept has found an increasing number of advocates in treatment programmes. This model emphasises the wider contextual, societal environment and the influences this represents or has on the addicted individual's behaviour. A combination of the two philosophies would seem to offer the best available treatment option for specific populations of Aotearoa (MacEwan, 1999). The holistic facets of socioenvironmentalism will in all probability be cross-culturally viable, and, more importantly, have an increased likelihood of acceptability for members of minorities.

In Canterbury, there are currently various drug and alcohol treatment facilities. However, many have only recently begun to offer services and others have undergone changes to some extent. In 1987, Johnston and Hannifin researched the available drug and alcohol programmes and published their results in a book titled *A Review of Drug Treatment Services in Aotearoa.* In the book, they outline eight services in the city of Christchurch and one in rural Canterbury. Of these, five have closed and another has relocated and grown into a more comprehensive health care provider. The increasing pace of change in the domain of addiction has rendered Johnston and Hannifin's report, except in a historical sense, redundant in 13 years.

This is an indication of the rapidly changing discourse researchers contribute to, which will also render this thesis obsolete relatively soon. For anyone wishing to avail themselves of a brief but current list of available services, the Alcohol Advisory Council of Aotearoa (ALAC) has a directory in the office (Level 4, General Accident Building, 77 Hereford St, Christchurch, PO Box 2688), or visit their web site at www.alcohol.org.nz; all enquires are welcome.

A Sociological Perspective on Addiction

A sociological interpretation of addiction focuses on the issues and reasons behind the definition of the malady, its treatment and consequential health, according to White (1999), and how these are in a constant state of flux (Radley & Billing, 1996). Sociologically speaking, if a person is defined as healthy, this represents a label with social implications. Those people who have a vested interest in promoting, providing, maintaining and continually monitoring health exert an influence which impacts on who is referred to as healthy (Spicer *et al.* 1994). Conversely, the same also applies to individuals labelled as unhealthy or in need of treatment. White argues that "what is defined as a sickness and how it is treated is not always a product of biological necessity, but is an aspect of wider social assumptions about what is appropriate behaviour" (cited in Davis & Dew, 1999; p.33).

How addicts are researched and treated by their society are indications of the dynamics involved. Social scientists who are funded by a provider with particular interests carry out addiction studies for specific reasons. Thus, how much funding, how expansive the research is, what exactly is being researched, and who is carrying it out, attest community providers' perception of addicts. The different emphases placed on researching subcategories in the population of addicts such as discrepancies in different cultures, gender, age and access to resources, are further indications of societal influences. If there are treatment centres and programmes for the majority of addicts but not for the minorities, then this suggests issues, which are adhered to or advocated by the primary resource providers in that particular society. The subcategories of addiction in relation to research of assessment and treatment are discussed in the relevant sections.

In a sociological interpretation of the subcategories, the reasons or underlying processes involved which influence the members of the specific populations are stripped away to reveal the primary dynamics. If subcategories of the main population of addicts are out of proportion with the demographics of the general "normal" population, then this suggests unequal antecedent social forces. To be more specific, if there is a higher proportion of addicts of a particular subcategory in comparison to the proportion of people living in lower social-economic-status housing, for example, then this indicates issues that need to be addressed. If it is known that these discrepancies exist and yet no

research has been funded, or even suggested, then this too must be perceived as an indicator of influential social factors. A comparison may be made, in another example, between the percentages of incarcerated members of different cultures in the same society. If a minority culture is overly represented in the justice system then this suggests acculturation issues that need to be identified and requires extensive sociological investigation.

An example of the intricacies of a societal phenomenon is the spread of a global plague that has multifaceted implications and consequences. Acquired Immunity Deficiency Syndrome (AIDS) is a pandemic catastrophe which is present in every country in the world. It has been able to infect people on such a ubiquitous scale for various reasons such as migration and travel, sexual mores, education and resource allocation, availability of information and access to literature, and personal intermingling in socially acceptable or deviant behaviour. Many of these interrelated facets, such as sexual mores, which all influence the spreading of AIDS, require intensive research because as a society we know very little about who does what to whom and why. One such area of information paucity is the syringe sharing habits of intravenous drug users.

AIDS awareness campaigns in Aotearoa have partially focused on the dangers of sharing needles which led to a public debate resulting in the Misuse of Drugs Amendment Act (1987) (Skegg & Cox, 1994; p.93). "Aotearoa was one of the first countries to introduce a needle and syringe [outfit] exchange scheme." Currently Aotearoa has, in comparison to other Western countries, a relatively low number of HIV positive addicts, but this could be because of increased education, our geographic location, economic factors, drug availability and costs, the "outfit" exchange scheme or simply good fortune. There would not be many people, however, who would argue that we should stop the exchange scheme or any other programme orientated towards improving education or access to treatment.

The Trend of Medicalisation

Throughout the last century there has been a trend to medicalise ever more aspects of our daily lives and addiction is no different. Medicalisation is the term used to describe the practice of referring to everyday health problems or issues expressed in medical

terms. Medical experts set the agenda and criteria by which the whole population categorises its actual health (Raeburn, 1994). Rather, it would be more productive to have the public set the agenda of what it is to be healthy or not and this would change with the informative comprehension of the community. Discourse could be provided by the experts who would serve people as professionals in a medical capacity instead of dictating their "Olympian view of what is 'good' for people" (Raeburn, 1994; p.342).

The stringent adherence to the biopsychological model, which has until recently been used as the primary ideological form of preferred treatment for addicts, is evidence of this influence. The medical dialogue regarding addiction has generated debates concerning abstinence and controlled use of psychotropic substances which is positive, but also primarily focused on addiction being a disease which requires treatment to heal. This has resulted in a concentration of members of the medical fraternity researching the physical nature of addiction to the detriment of clients by negating the influential social environment. Some medical researchers are currently looking for a specific addictive gene, which if present would increase the likelihood of an individual's propensity to becoming addicted, and others argue that the reoccurring maladaptive cyclic pattern of behaviour is predominantly socially learned. There are many areas of contention in the medical domain.

In the coeval population of Aotearoa health care providers, there is a constant struggle in health care institutions between administrators and health professionals. That is, instead of being able to focus on healing patients, many health professionals devote time and energy to selecting who has the most urgent need of their skills. Moreover, health is now a firm fixture in the political arena (Te Rōpū Ranganau Hauora a Eru Pōmare, 1999). These issues have implications for the amount of funding available for the assessment and treatment of addicts.

Access to limited resources generates rivalry between the service providers for the available funds. This limitation will have subsequent negative effects on the overall choices available to prospective clients. The professionals in the addiction treatment programmes must devote time and energy to staying level with or ahead of their competitors rather than dedicating all their efforts and skills to helping addicts. Moreover, this style of health service does not promote the collective open sharing of knowledge and resources that would, ideally, offer better research opportunities and potentially

improve treatment for all psychotropic substance dependent clients if it were not limited or hindered in this manner.

Ironically, most healing takes place removed from established health care providers, according to Nettleton (1995). In Aotearoa, the tendency is to place more emphasis on community care rather than institutional respite. This practice of placing the welfare responsibility back onto the community raises numerous issues. It is in the wider societal context that all addicts begin to use psychotropic substances. Many people in our society use mind-altering substances, both licit and illicit, on a daily basis. An interesting current trend is that as a nation we seem to be smoking less tobacco and drinking less alcohol than before the eighties and early nineties (Ministry of Health, 1998). Conversely, in a news item it was announced that approximately 30 percent of people aged between 18 and 24 drink more than the daily recommended amount of alcohol (Television One Network News, 2000). There is, however, a problem with estimating numbers of addicts and illicit drug consumption, as the trend seems to be one of survey under-reporting. This may be a consequence of individuals avoiding identifying themselves for fear of potential punishment.

One of the positive outcomes of addiction issues in Aotearoa is the establishment of the Alcohol and Public Health Unit at the University of Auckland, which has generated a great deal of quantitative and qualitative methodological research (McKailay *et al.* 1999). The existence of such a specific unit is an indication of the need for it. The generated information and research ability of the staff in the unit attests the level of importance placed by the primary resource providers on the effects of the dynamics between society and addicts and for the addicts themselves. That there is only one such specialised institution in the country suggests other underlying influential factors, such as limited resource allocation or hierarchical fund beneficiaries, in Aotearoa.

Treatment Issues

The lack of expertise evaluating the treatment of addicts is one aspect of the domain that requires more research, as there is a lack of information about it in Aotearoa. Three prominent Canterbury addiction professionals note that there are many salient issues concerning treatment such as:

1. The many conceptualisations of alcohol and drug problems, and the variety of intervention models that exist;

2. Limited Aotearoa guidelines and standards for the treatment of alcohol and drug problems;

3. A heterogeneous client population which encompasses gender, age and cultural diversity;

4. The multidimensional and frequently episodic nature of alcohol and drug problems which may require multiple agency input and multiple interventions over a long duration;

5. The variety of services and diversity of service setting, including rural and urban settings;

6. The 'real-world' context of service delivery;

7. Differing structural arrangements of drug and alcohol services, e.g. some situated in Mental Health Service structures, others stand alone;

8. Workers with a range of understandings and views, qualifications and clinical experience;

9. Lack of agreed-upon evaluation frameworks, the variable status of evaluation in alcohol and drug services and the availability of skilled personal and other resources;

10. How to meaningfully involve consumers and referrers in evaluation activities.

(Deering *et al.* 1999; p.5).

Extensive research regarding the treatment of addicts in Aotearoa is required before any substantive conclusions may be drawn about the addicted population, their rates of consumption, the damage to individuals and society, the treatment regimes, client co-morbidity or multiple diagnosis, specialised staff training and the successfulness of treatment outcomes. This must cover the entire range of interaction between addict and

the health care system from first contact to a comprehensive post-treatment process and the ongoing assessment of long-term changes of behaviour (Lindstrom, 1992).

Research suggests that many potential clients have already initiated behaviour changes before presenting at a drug treatment programme (Tucker, 1995), implying that the treatment they receive consolidates the behaviour changes rather than instigating them. Moreover, most cognitive schema learned during treatment is eroded after twelve months (MacEwan, 1999) and it again places greater emphasis on the social environment the addict returns to after treatment. A supportive environment is potentially more likely to yield long-term positive growth for the addict in comparison to a negative social setting.

MacEwan (1999) defines treatment intervention as three distinctive levels: these are Primary, Secondary and Tertiary provision. Primary treatment incorporates a brief intervention and early therapy dynamic between health professional and client. Tertiary intervention applies to short-term intensive treatment in specialised settings. Between these two is Secondary which involves "supportive counselling, welfare and basic medical care for chronic alcohol and drug dependent people" MacEwan (1999; p.15). It is presumed, because of the discrepancies in our society's institutions, that various subcategories of addicts require different amounts or levels of the three interventions to increase the chances of positive behavioural changes. Interestingly, MacEwan distinguishes between people addicted to drugs and alcohol.

Different minorities of the population require specific or specialised treatment to increase the chances of a successful reversal of the maladaptive addictive patterns which initially bought them to the treatment centre. Many individuals who identify as members of minorities do not find adequate or sufficient treatment in mainstream facilities and seek help from members of their own culture, gender, religious, or similar sexual orientation groups. Currently our society only offers treatment for some of the minorities in the population. Many addicts turn to other forms of treatment for help.

Non-Researched Addiction Treatments

For people wanting help with addiction related problems there is a diverse range of interventions they can choose from in Aotearoa. Several of the alternative treatments, those which have not been researched enough to be accepted by professional mainstream providers, are nevertheless widely established and approved by the majority of treatment caregivers and clients in the domain of addiction. Several of the predominant treatment groups are based on a twelve-step programme, founded in 1935, by Bill W. (Galanter, 1999). His last name is not provided for reasons of anonymity which also form a central philosophy of the twelve-step groups and, additionally, because he was also a member. The programme he initiated is called Alcoholics Anonymous (AA) and has recently led to the formation of several other twelve-step programmes.

One such programme is Narcotics Anonymous (NA). AA is normally attended by anyone who identifies as an alcoholic, while NA is usually frequented by individuals with drug related problems. The distinction between the two groups by certain members and others is something that adds to the confusion about addiction. Alcohol is a drug and an alcoholic is an addict. Both groups hold regular open meetings that may be attended by non-addicts, but numerically these meetings are small in comparison to those for just the members. Members of the public may come to open meetings of both groups, but are ordinarily asked to listen to the experiences of addicts. Another group dissatisfied with the treatments offered and the philosophy of AA and NA became Rational Recovery (RR). The twelve-step programmes emphasise a belief in a higher power, while RR places the point of power in the individual and focuses on cognitive schematic changes. Central to all of these types of programmes is the belief that "an addict can be helped by other addicts."

The twelve-step programmes also have twelve traditions by which they govern their continuing existence and regulate their members' behaviour. Galanter (1999) suggests that one of the reasons twelve-step groups are so successful is that they are similar in maintenance and recruitment practices to charismatic religious sects. "Members of AA healing groups are highly cohesive; they maintain a system of shared beliefs and their behavour is strongly influenced by the group" Galanter (1999; p.211). Later, in the book, he argues that there are also contrasts between the sects and substance recovery groups, which promote the continued existence and growth of twelve-step programmes.

A distinction between them is that religious sects tend to have a universal influence on their members' lives, while recovery group adherents are taught to focus on changing their dependence-associated behaviour. In this way twelve-step groups tend to promote changes in their members' lives while religious sects ostensibly intend to change the world (Rose, 1982). There has been research regarding the efficacy of twelve-step programmes, but not enough to be conclusive (MacEwan, 1999).

Another recent development in the treatment of addiction is pharmacotherapies. In the past, pharmacotherapies have been used to reduce the torment of withdrawal experienced by addicts during detoxification. Recently, however, there has been a move to use it to prevent relapse and pharmacotherapies are being increasingly studied as another tool that may be used in conjunction with other treatments. Erikson (cited in McNell, 2000), a visiting American pharmacologist, argues that addiction is a medical disease and that there is certainly not enough data about addiction as a disease, or the pharmacology of addictive drugs. Moreover, he contends that a great deal of research needs to be conducted because it will help to dispel the confusion of the public regarding addiction, drug use, pharmacology, prevention and treatment.

Miller *et al.* "list a number of treatments for which there are too few controlled outcome studies to support their use by providers....[They] include:

- sensory deprivation
- developmental counselling
- acupuncture
- exercise
- aversion therapy
- problem-solving training
- functional analysis
- self-monitoring
- antidepressant medication

- blood alcohol discrimination
- antipsychotic medication
- Alcoholics Anonymous (see above)

Again caution is required as the studies all refer to these treatments as stand-alone. Many of the above are rightly used in combination with other therapies or as an integral part of a more comprehensive intervention (Miller *et al.* cited in MacEwan, 1999; p.36).

The fact that only one in five addicts make use of recognised treatment centres, and that these non-researched regimes continue to exist and thrive, suggests that the majority of addicts turn to these alternatives for help in maintaining behavioural changes. Conclusive research regarding these forms of therapy is necessary before any future directions in the field of addiction may be postulated.

Assessment Issues

Professional members of the contemporary addiction milieu prefer to call assessment of the process of treatment clinical audit rather than medical audit. Clinical audit is a system whereby gatekeepers or those individuals who are responsible for the initial contact with clients are themselves appraised to confirm if they adhere to particular standards and guidelines. This monitoring of activities is essential to ensure what is being offered is the best possible treatment the centre or programme can provide. An integral aspect of this is ensuring staff are appropriately qualified (O'Hagan *et al.* 1993), and verifying that standards are being met in providing care for clients (Deering *et al.* 1999).

A component of assessment evaluation is the incorporation of the addict in clinical audits. However, this in and of itself is extremely problematic. Clients' satisfaction with the service they receive involves multidimensional facets such as past health care experiences, expectations, reasons for seeking help and acknowledging that the issues involved, such as what is healthy, cannot solely be defined by the health professionals or even the addicts themselves. In addition, it may be morally reprehensible to ask people

to become involved with such a process when, in the early stages of behavioural modification, they would benefit from focusing their entire energy on themselves, the process and goals they are attempting to reach.

Initial screening and assessment needs to be conducted once the client has become more stable and this is problematic, given the inherent reasons the person has presented. Many addicts, in order to continue their maladaptive behaviour, have become proficient at deception, some perhaps even more so at self-deception, according to Mattick (1992). It is at this crucial stage that the client requires effective assessment, extensive diagnosis and individualised screening. It is vital that this process occurs successfully at the initial contact, which, however, is fraught with difficulty. Furthermore, although each appraisal needs to be comprehensive, "it is not feasible or necessary for every individual seeking assistance. [I]t is important for workers to have a thorough understanding of the process so they can perform it themselves or arrange for other, appropriately trained workers to complete the task" (MacEwan, 1996; p.4).

Co-morbidity or Multiple Diagnosis, Assessment and Treatment

In the past individuals who presented with co-existing disorders were regarded as belonging to a problem subgroup of addicts requiring more exhaustive treatment, with potentially higher relapse rates and poorer outcomes. According to Friedman *et al.* (1993), McLellan *et al.* (1993), Moos *et al.* (1996), and O'Hagan *et al.* (1993), between 30 to 40 percent of those entering treatment have a psychiatric disorder. The existence of multiple psychiatric disorders will influence the client's outcome in assessment, programme matching, treatment and goal attainment.

Recent research (Schuckit, 1997) suggests that there is a high overlap between drug dependence and psychological disorders. However, for many addicts the symptoms of psychological secondary or other associated disorders are usually present only in the initial stages of treatment. MacEwan (1999) argues that clinicians seem to rely on the *DSM-IV* criteria, assume that this is sufficient diagnosis and assess clients' needs accordingly. Meeting the criteria does not necessarily mean that the clients have the disorder. Solely or predominantly relying upon the *DSM-IV* may mean that there are

other issues not being addressed, such as different cultural values or minority group memberships or affiliations.

Cultural Issues

In Aotearoa we live in a cultural melting pot contributed to by people from all over the world. Although we were a predominantly bicultural society the Pākehā majority, until recently, did not acknowledge the indigenous population of Aotearoa in many ways. The Māori have had to deal with racist laws and philosophies since colonisation by imperialist Europeans and this has been reflected in the unbalanced composition of cultural representation in the legal, health and educational institutions of this country.

Māori people are more likely to present, at service providers treating drug related issues, with two or more psychological illnesses (MacEwan, 1999). In addition, Durie (1998; p.86) contends that "Māori requiring treatment for alcohol problems are more likely to be admitted into a forensic or hospital setting than to be managed in a community clinic." It seems that the Māori are receiving different health care to that of the Pākehā. Dyall (1999) argues this discrepancy may be because health professionals are uneasy with promoting unrestrictive strategies. A discussion of reasons for this discrepancy between the different components of the population, such as demographic concentration and heterogeneity of the indigenous or First Nation people (Fleras, 1999), is offered next.

The Māori

In Aotearoa we have a unique past in which representatives from two cultures signed a treaty, known as the Treaty of Waitangi, that should have laid the foundations for equality and fairness. The government of Aotearoa recognises the Treaty "as the founding document of Aotearoa" (Te Māori me te Waipiro, 1995; p.11). In the Treaty there are provisions and principles that clearly define the government's role as a partner, participant and active protector of Māori and Māori interests. The significant discrepancies between Māori and the mainstream population in our culture, however, indicates there are many issues which need to be addressed (Dacey, 1997). Adherence

to the Treaty should have established the groundwork for a fair and mutually respectful relationship between the partners.

Demographic information regarding all aspects of this society, such as health, education, legal and economic status, suggests that this has not happened. In the health sector, for example, Māori have a higher than average rate of admission into psychiatric hospitals for drug dependence (MacEwan, 1999). This is particularly true of Māori men, although Māori women are also over-represented in these institutions.

Māori people present with greater than average co-morbidity of psychological illnesses, are more likely to remain in restrictive treatment, and are readmitted more often. Research by Awatere (1984) suggests that many First Nation people do not seek help from health professionals unless they are forced to do so. The issues, which keep four out of five addicts from seeking help from mainstream providers, would be intensified for members of a denigrated minority. This discrepancy between the cultures could be because of different cultural values; miscommunication because language and its inherent meanings are at times ambiguous even between two people of the same culture; unusual contexts and an unfamiliarity with the cultural implications would lead to inappropriate assessment, treatment, goal targeting and maintenance.

"Overall the risk of disability and death from alcohol related harm is approximately twice as high for Māori than non-Māori, for both sexes and all age groups" (Te Puni Kokiri & the Alcohol Advisory Council of Aotearoa, 1995; p.9). Māori and Pākehā share the same environment and are all influenced by capitalistic, Westernised globalisation to some extent, and yet European members of this society, who comprise the majority of the population, are only half as likely to suffer from alcohol-related issues. These differences indicate that the Māori people do require specialised treatment, which they are not receiving from mainstream health care.

To assume that the first people to settle in this country belong to a homogeneous group or culture compounds the morally reprehensible position of mainstream Aotearoa (Durie, 1998). Māori is the name given to Aotearoa's indigenous or First Nation population but they consist of many different iwis, and in coetaneous society there has even arisen a new group known as Urban Māori. This has implications for their assessment and treatment in programmes regarding drug-related issues.

Changes in mainstream drug programmes are urgently required. Recently, in Christchurch, a drug treatment facility by Māori for Māori has been established. Two contemporary culturally specific centres which cater for Māori in the Canterbury area are Te Rito Arahi in Christchurch, and the Taha Māori programme at Queen Mary Hospital, in Hanmer Springs. Research undertaken by Huriwai *et al.* (1998) found that Māori attending Māori programmes are more likely to remain drug free than those attending non-Māori programmes. They also noted, however, that there is a lack of data and further research is required.

Many Māori people do not have the opportunity or inclination to attend these programmes and instead are referred to or seek help from mainstream facilities and professionals. In a report detailing specialist drug and alcohol treatment centres in Aotearoa, MacEwan (1999) suggests, on pages 71-76, that there are many ways in which treatment for First Nation people may be facilitated to a higher degree of success. Essentially the main emphasis of culturally relevant information presented by MacEwan is that there is a lack of understanding about all aspects of addiction and how this relates to and is experienced and expressed by the Māori people. Consequently, as a nation we need to increase our understanding of acculturation issues, of what it is like to be a member of the Māori community in Aotearoa. The staff of mainstream health institutions and facilities do not have enough knowledge about the Māori and all non-Māori treatment providers need to have higher levels of cultural awareness through increased education. An expansion in the education of the mainstream health providers regarding Māori is a step towards becoming equal partners.

Durie (1998) argues Māori are being discriminated against in every facet of this society and therefore it must affect the drug treatment process in its entirety. These effects range from an increase in the risk of lower health care for addicted pregnant mothers and a higher infant mortality rate to over-representation in every aspect of institutional care in this culture. The Māori people have been pressured into acculturation and are still suffering from discrimination at every level of this predominantly Western European nation. Solomos and Back (1996) contend that racism is still as strong in current Pākehā communities as it was in the past, just that it has changed in its presentation and representation.

People of many cultures live in this country as, neighbours, friends, associates and work-mates, yet on average Māori are dying at younger ages and experiencing more medical ailments. Māori health has multifaceted social, economic, political, cultural and spiritual factors (Reid, 1999). All of these issues need to be rectified if the Māori people are to have equal opportunities in this mono-culturally dominated society. There needs to be a greater emphasis on all aspects of the Māori culture, by the primary health care providers of this nation. Recently, however, members of other cultures in Aotearoa have begun to present at drug treatment programmes.

Pacific Island People

Pacific Islanders, according to Finau and Tukuitonga (1999), consume less alcohol than either Māori or Palangi (European). They argue that 57 percent of Pacific Island individuals do not drink at all compared with 12 percent of the general population who do not consume alcohol. In addition, alcohol problems in the Pacific Island population seem to be extremely rare. Proportionally speaking, however, Pacific Island people comprise a higher percentage of the incarcerated population than their demographic suggests. The transgression of legal boundaries is frequently associated with drug-related problems (Adamson, 1997), and it could be argued that this is indicative of issues that need addressing.

The Pacific Island population is also not homogeneous and therefore their treatment should be heterogeneous. Many people who identify as belonging to this elaborately composite population seek help from Palangi treatment professionals but find it insufficient. In the past, Pacific Islanders experienced less behaviour modification maintenance and substance-free goal attainment by using mainstream health care providers, which meant treatment was not as successful as it could or should be. Now, in Christchurch, they can turn to the Pacific Island Evaluation Inc., which was begun because the founder perceived the need for it. Again, however, as with every other sub-category in the domain of addiction, there is not enough available information to allow for any conclusions about this programme to be reached other than that there is an urgent need for assessment, treatment and more information.

Gender Issues

Feminist critique of medicine has resulted in positive changes for women requiring health care and an increase in the number of female doctors. One drug-related difference between the genders is that women are more likely to suffer from depression and therefore consume more mild psychotropic drugs then men (Te Rōpū Rangahau Hauora a Eru Pōmare, 1999). However, every type of illicit drug is more likely to be used by males and their recorded drug related offence rate has risen steadily since 1980 (Department of Health, 1992). A recent trend is the reduction of differences between the genders, and this decrease indicates growing problems. One of the reasons, according to the report, was that women in the past did not readily admit to using drugs and seeking help because they were afraid of being stigmatised (Goffman, 1986) as people with substance dependence problems. Due to the reduction of the gap between the genders it could be argued that there has been a potential reduction of the fear of stigma associated with being labelled an addict.

Research has found that pregnant women who use psychoactive substances might damage the foetus. Alcohol, for example, crosses the placenta and equilibrates at the same concentration in both the mother and foetal blood stream (O'Hagan *et al.* 1993). Frequent use of alcohol may lead to foetal alcohol syndrome and this could increase the chances of malformation or a spontaneous abortion. Socially acceptable or legal drugs such as nicotine, caffeine, benzodiazepines and opiate derivatives such as morphine may also harm the foetus during pregnancy. If a pregnant mother shares intravenously then she and the unborn baby also run the risk of contracting infectious diseases. If a mother has used psychotropic substances during pregnancy the infant could be addicted and experiencing withdrawal symptoms at birth.

Women are, however, still more likely to negate seeking help due to "denial, stigmatisation, and embarrassment" according to MacEwan (1999; p.60). In addition, many women living in rural and urban areas experience difficulty locating suitable services, paying required costs, and placing their children in childcare during treatment. There is a paucity of research regarding treatment for women with drug-related problems not only in Aotearoa, but throughout the international addiction arena as well. Recently, in an attempt at filling some of the gap, the Alcohol Advisory Council of Aotearoa (ALAC) has issued a report titled *Women and Alcohol* (Gray & Norton, 1998).

The main findings of a second report by the same researchers were that there is a lack of information about how women experience drug-related problems, and that this is exacerbated by the ignorance of health professionals and individuals in social support services in general. Suggested changes are:

1) Drug treatment services specifically for and staffed by women

2) An increasing emphasis upon raising education levels for women and society at large

3) An increase in funding, and appropriately trained staff

4) Appropriate childcare facilities and support

5) Increasing cultural awareness and speciality requirements

6) A more comprehensive involvement by society in providing care and encouragement for the treatment centres and programmes (Gray & Norton, 1999).

According to Berry (1997), 30 to 75 percent of women presenting at centres are likely to have experienced childhood sexual abuse and this has massive implications for assessment and treatment. Women suffering from sexual abuse in the past are less likely to complete treatment, have higher rates of relapse, and are less likely to divulge parts of their past unless the service is gender sensitive. Because of the pervasive ramifications of sexual abuse, women who have suffered it are also more likely to present with co-morbidity issues which compound any interactions with health care providers. Due to its sensitive nature sexual abuse is at times negated in screening, assessment, client matching and treatment. Sexual abuse must be identified, confronted and resolved if a person is to increase the chances of improving life's potential quality. People can only successfully achieve this in a gender-sensitive service and therefore these need to be available to both genders.

Māori and Pacific Island women have additional issues that need to be addressed by all staff at drug treatment services. Aotearoa's population is comprised of multiple cultures and this poses a vast array of issues when treating women from other cultures in predominantly Westernised health care facilities. As mentioned before, the dearth of

research and consequential lack of evaluation data is one of the fundamental issues that require immediate attention. This is especially true with regard to different cultures, specific needs and gender issues in the drug programmes in Canterbury.

Adolescent Assessment and Treatment

The lack of relevant data about many specific sub-groups of people who are dependent on psychotropic drugs is again a main issue with adolescent or young adult addicts. There are many different philosophies and treatments offered by health care institutions and facilities, but evidence that they are in fact providing even adequate treatment is sparse. The research does indicate that substance abuse amongst adolescents is "particularly fluid and characterised by continuous and rapid changes in prevalence and patterns" (Swadi, cited in ALAC, 1998; p.76).

Adolescents may present at a drug centre or treatment programme with a varied range of "health disorders, psychiatric disturbances and psychosocial maladjustments" (MacEwan, 1998; p.9). The assessment and treatment of adolescent addicts is therefore psychologically and physiologically intensive, time consuming and needs to be comprehensively integrated in an eclectic multi-model approach (Peterson, 1989).

It has become apparent that the younger the initiation, the more likely it is that continuation of the behaviour will occur, and the more vulnerable the young user is to the adverse effects. One of the patterns which has emerged in Aotearoa is the higher than average proportion of Māori and Pacific Island youth needing treatment for drug-related problems (MacEwan, 1999). In addition, it has become clear that adolescents stay longer if they are in specific services or treatment. That is, if young people are in mainstream homogeneous care, they leave earlier.

An approach, until recently largely ignored by the biopsychological model of treatment for adolescent drug-related problems, is the socioenvironmental methodology. A more holistic emphasis, where the young person is seen as a complex whole with many diverse patterns and behaviours, which are all intertwined and linked, will lead to better behaviour modification outcomes. There is, however, a lack of direction and standard

practice for treating adolescents and, as before, the need for more research is paramount in achieving any successful implementations.

Adolescents have recently presented with higher rates of co-existing, multiple personality, and eating disorders (MacEwan, 1999). The need for a standard level of health care, professional training and nationally recognised qualifications is particularly high with regard to the treatment of young addicts. These issues are compounded if the adolescent client is a gay male or lesbian female. For a homosexual teenager or young adult there could be "coming out" pressures such as family and peer rejection, and homophobia exhibited by staff and other clients. This group of people "must be considered as a high-risk group for suicide" (Spooner *et al.* cited in Deering *et al.,* 1999).

The Gay and Lesbian Community

This is the subcategory with the least amount of available data. Deering *et al.* (1999) note that gay men and lesbian women have specific health issues that must be taken into consideration. Many gay and lesbian people may feel intimidated in a predominantly heterosexual drug treatment centre. They may then be reluctant to disclose their sexual orientation, private feelings, thoughts and issues, which need to be addressed in order to receive help and improve their chances of changing their substance-dependent motivated behaviour.

Many gay and lesbian people have possibly experienced discrimination in the predominantly heterosexual community, which they probably do not wish to confront when they are seeking help. This pressure to conform might unintentionally be exerted by some health care professionals. Furthermore, programme staff may feel discomfort and reluctance at expressing their own sexual orientation or experiences and this will not increase the feeling of acceptance or a safe environment to explore personal issues for the homosexual addict.

MacEwan (1999) argues that gay and lesbian addicts require specialised treatment because their outcomes are less successful than those of the heterosexual community. Since gay and lesbian addicts are treated in the mainstream population and yet have poorer than average outcomes, it can be inferred that this is partially due to the negation

of values and beliefs they hold important. There is currently, however, simply not enough research data to lend any weight to this hypothesis. Until specialised programmes are initiated and relevant information is obtained there will not be any valid conclusions.

In Summary

There are, in all Western societies, many different facilities and regimes for the treatment of addiction. Not all of these are recognised by the professionals and researchers in the field of addiction, but many continue to function and prosper: an indication that they are patronised by addicts. Throughout this chapter one of the recurring themes has been the paucity of information concerning many facets of addiction, and one of the first areas which requires immediate research is the many divergent forms of treatment on offer. The therapeutic options for addicts are enormous, and those addicts with access to relevant treatment information are in a better position to choose which might best suit them. This, of course, would not be possible for court referrals, when offenders must present at a centre or programme and undertake the specified length of treatment.

A second theme is the dependent relationship between addict and health care centres and programmes, and their reliance on the resource providers. Initially there may be some disagreement over who exactly is an addict and how they became addicted, which, considering the multifaceted interrelated malady, is understandable. That this variance continues throughout the entire treatment process is, however, morally reprehensible. Until recently this may have been influenced by the reliance upon the biopsychological approach and resulted in severe deficiencies with regard to treatment options for many people. In contemporary society, however, there is more emphasis on the socioenvironmental method, which incorporates the previous model in an eclectic, holistic manner with a higher likelihood of both promoting fulfilling lives for addicts, and being accepted by members of minority groups. The increasing use of socioenvironmentalism should also reduce the emphasis placed on medicalisation, at least in the domain of addiction.

The third theme is the dynamic relationship between the addict and wider society. How much relevant information and how many consequential services are available to

addicted individuals and health care providers are pivotal to successful goal attainment and an improvement of life. The initiation of services for addicts by other addicts and by members of minority cultures indicates that services offered in the past were not providing what was perceived by many as the optimum treatment. Drug centres and programmes have only minimally increased or improved society's understanding and therefore offered only slight enhancement to combating an addiction to a substance. This is directly related to the small amount of available funding and resource allocation.

The presence of alternative services will also increase the available information concerning addiction, which will improve the possibility of more successful treatments. In the not-too-distant future, resources should be made available to establish centres or programmes for members of minorities such as the gay community.

Chapter 3

Methodology

Introduction

This chapter outlines the philosophies and the methodology used to obtain information from interview participants regarding addiction in Canterbury. There are many issues that need to be taken into consideration before a researcher may arrive at an actual interview. The first of these is that all research conducted by any social scientist is ethical in nature. Indeed, the inspiration for this research is the moral dilemma facing our community and the growing number of people suffering from a dependence on mind-altering substances and, consequently, a lessening or reduction of life's enjoyment and having a negative impact on society.

The entire domain of addiction treatment currently suffers from a lack of relevant information, outlined previously, which influences the opportunities or possibilities suffering addicts have for help and has extensive implications for professionals in the field. The first section of this chapter offers a brief description of ethics and morality, which is followed by a piece on confidentiality and consent. These are not clearly definable areas and are, therefore, offered first to establish a frame of reference for the rest of the chapter. This chapter focuses on the initial formulation of the hypothesis, outlining the methodology and presentation. A common mistake is to forget that the relevant issues in wider society are magnified in the addict community. Everything in this chapter is related to obtaining information from people for the purposes of comparison, and increasing the understanding social scientists have of the forces which influence the community they live in.

Ethics and Morality

The pedagogy of the social sciences by its very nature contains ethical implications because of the subject matter. That is, the individuals who place themselves in the canon of sociology (Seidman 1996), which is one of the social sciences, should not adhere to or advocate philosophies, policies, ideologies or methodologies which are

morally wrong or ethically questionable. According to Beauchamp (1991; p.5) ethics and morality are one and the same and neither can "be confined to *philosophical* contexts" (original emphasis). Every aspect of this thesis has ethical considerations or implications. The subject matter, the methods used to gain information and how that data is managed and ultimately presented, must follow moral codes of behaviour stipulated by the university's Ethics Committee and the Sociological Association of Aotearoa.

Throughout the remainder of this chapter the words ethics and morality will be used interchangeably to refer to a single concept. This thesis describes policies and methodologies adhered to by staff in drug treatment centres. The information collecting tool is the interview, which is " the most widely used method of research" (Fielding cited in Gilbert, 1996; p.135). Considering, then, the pervasive and ubiquitous scope of ethics, it was thought prudent to provide clarification at the beginning of this chapter.

Moral Rules of Conduct

The Canterbury University Ethics Committee requires a form to be submitted before any work could progress on the thesis and this was successfully completed and approved. The Committee, as part of the form appraisal, has judged the information that will be provided to the participants as suitable and adequate. The ethics form also provided a strict guideline from which appropriate behaviour for the social construction of the interviews could take place.

Ethically Correct Behaviour

The safety of the participants is paramount during interviews. The potential of physical injury is negligible but the possibility of psychologically harming interviewees is at all times a principal concern. The risk of psychologically disturbing interviewees is always present and is incredibly difficult to ascertain. This is exacerbated by the danger of expecting that since the participants are all therapists or counsellors if the interview becomes uncomfortable, for whatever reason, they should have the skills and psychological cogency to change the situation to alleviate their anxiety or distress. More

positively one of the factors making the interviews slightly less problematic than interviewing a member of the public, is that the participants are all professionals and the topic is their chosen career. Every effort has been made to ensure that the participants do not suffer "stress, fear, or anxiety" (Reaves, 1992; p.41).

Two of the interview participants identified as members of minority cultures. Members of minority cultures may have different "beliefs, values, customs, habits, and behavour shared by a group of people in a particular society" (Cockerham, 1995; p.66). When such a situation arose the researcher asked for clarification from the participants on how to behave during the interviews before progressing and possibly blundering through norms of another culture. The potential implications of the difference between cultures will be explored in more detail later.

Practical Reality Checks

The non-standardised interview did not proceed unless the interviewees replied that they understood that they could temporarily or permanently withdraw from the process at any stage and that the data would be destroyed if they desired. Throughout the entire exercise efforts were made by the researcher to ensure that the people being interviewed continued to feel comfortable and that the topics covered did not cross any personal or professional boundaries.

To ensure that the interviewees did not suffer from emotional or psychological distress, openings were left in the conversation, occasional probes used and ample opportunities provided to discuss any concerns they may have. These were given the researcher's undivided attention. Throughout the entire process it was hoped that the participants realised that they were in control of the interview.

Confidentiality and Consent

To maintain confidentiality and anonymity, participants have not been named. Each individual signed a consent form, but only the researcher and thesis markers will see the forms. The names of the participants have been withheld and the only piece of data

connecting them to the interview is the consent form (see Appendix D). Because there is absolutely no inducement once the people agreed to the interview it was taken as granted that they were not being coerced and that their participation was voluntary. Following the marking of this thesis the consent forms will be destroyed in accordance with the stipulations contained in the *University of Canterbury Ethics Committee Guideline* (1998).

Although the treatment programmes are identified, the names of the therapists will be changed, corresponding to the first letters of the alphabet. The first interviewee, however, is referred to as participant H, while the second as B and so forth. Labelling a source as A was considered problematic. Particular details that contribute to validity and reliability and have been retained in the thesis. Details such as cultural identification, gender and religious affiliation are identified if they are perceived to influence the policies or methodologies of the programme and, consequently, the treatments provided.

The recorded interview data was deleted by each interviewee after it had been transcribed into the researcher's computer. Then, after the correlation of the information, all the transcriptions were deleted in accordance with the *Ethics Committee Guideline*.

No deception was required by the research design. Deception may be either active, as in deliberately false statements, or passive (Reaves, 1992), for example, omission of information. At the beginning of each interview, participants were asked if they had received and read the letter of introduction. They were then given an interview topic guideline, an information guideline and a consent form. Therefore, it was assumed that the participants, on signing the form, acknowledged fully informed consent. There was no need for a debriefing session because there was no active or passive deception.

Theory Construction

To obtain a sociological understanding of the world, sociologists seek to discover and comprehend the facets of our society which influence us in our everyday lives and affect our cognition and behaviour. A primary resource for sociologists is theoretical and factual information accumulated over time. All research is theory dependent, combining

"the historical, experiential and critical dimensions of sociological understanding" (O'Brien, cited in Gilbert, 1996; p.13).

The goal of scientific investigation is said by some (Abercrombie *et al.* 1994) to be objectivity. Objectivity, by definition, is free from bias or stereotypical prejudice, but other sociologists argue that this is simply not possible. That is, objectivity cannot be generated by humanity because we are subjective, we use limited language meanings, we create and tend to adhere to particular theories, our observations are theory laden, and groups and people produce arguments that are influenced by values (Abercrombie *et al.* 1994). Conversely, other social scientists contend that it is not necessary, realistic or possible for sociologists to produce objective information all of the time. Moreover, it is argued that sociology should be critical and adhere to particular values. This thesis incorporates both subjectivity and objectivity, and is, therefore, not quintessentially either. The argument for the inclusion of both is presented in the section titled "Stereotypical Categorisation."

Hypothesis Formulation

The hypothesis which guided the generation of this thesis is that there are different drug treatment centres which use or promote diverse ideologies, and that individuals with drug dependence issues may have improved chances of successful goal attainment if they were aware of the various treatments offered by facilities in Canterbury. Therefore, it was decided that to interview one staff member from each programme of a large proportion of the facilities was more likely to be successful than other forms of research. Though some argue (Olson & Defrain, 1994) that people are more honest in questionnaires, the unstructured interview enabled the researcher to expand on specific topics with participants.

It must be noted, however, that although the therapists are all professionals in their fields, they are being asked their opinions and thoughts about their respective treatment centre's policies. The information obtained from the interviews is correlated to compare the different rationales provided by the interviewees. To gain a more comprehensive understanding and increase the validity and power of potential generalisable data, more staff at the centres would need to be interviewed.

Only one staff member from each centre was interviewed and this resulted in a collection of seven individual opinions. By interviewing a staff member it was possible to identify polices advocated by employees at the centre. Goffman (cited in Giddens, 1997) contends that the presence of the staff makes the interview with the participant possible, and that the two are interdependent. That is, because the questions elicited pertinent information, the main policies of the centre were ascertained. Even though the two spheres of the same facility are interrelated, there was only one interview. Further investigations should, by striving for more objective data, conduct interviews with multiple staff members of each respective facility.

Validity & Reliability

There are two issues of vital importance for any piece of research; these are validity and reliability (Plummer, 1983). To make research reliable the methodology must be meticulously recorded so that other researchers may be able to replicate the study and obtain similar findings. Validity refers to measuring internal consistency, or ensuring the study is researching what it purports to research.

According to de Vaus (1995), there are numerous sources of unreliability, but reliability may be enhanced and tested. Vague questions, individual motivations, length of elapsed time and language all have implications for reliability. Asking the same question in an identical manner several times during the interview or several weeks later, produces answers that may be correlated and appraised. In this thesis time was of the essence, and consecutive interviews or repeated questions were not feasible, which precluded improving reliability by these methods. The same questions, however, were asked of each participant.

There are several different aspects of validity: face, criterion, construct and content validity, which are, realistically speaking, more difficult to measure than reliability (Reaves, 1992). Face validity requires merely a brief appraisal, which is not a good measurement. Criterion validity is a comparison to related material other than that which is being measured. This thesis, for example, can, after the interviews, compare the data to other relevant information relating to the same topic. Measuring construct validity

compares the results of other measurements of the same construct, according to Procter (1996).

It was hoped that there would be nine interviews and that these could be compared, to produce a limited form of construct validity. In the end there were seven interviews and this has reduced the validity. Content validity occurs when a piece of research has measured all the important theoretical aspects of the construct as decided by a group of experts. The content validity of the interviews may to some extent be impossible to measure because the number of experts in the domain is small and they may not agree due to the extensive nature or scope of addiction. Validity and reliability, and limitations such as resources and time, were taken into account when deciding the style of interviews and questions.

Research Questions

The scope of the material that may potentially arise during the interviews is vast and, accordingly, it was decided that the non-standardised interview would be the best method of asking professional drug therapists about their centre's policies. The number of different types or styles of facilities to some extent reflects the multifaceted malady of addiction. Although the interviewees are all drug therapists or counsellors, this variety inherently requires a certain amount of freedom in the interview style and questions.

Although the drug programmes provide services to members of the general population and they have many aspects in common with each other, they also have vast differences such as, for example, identifying with other cultures. This places each facility in a unique position and therefore requires pertinent questions that take into account their individuality.

The questions were asked in a conversational style of interviewing because conversations have less rigid rules than other forms of social interaction, such as formal or legal social interactions. This allows for a

> degree of relaxation...[which] is made possible by a set of implicit rules or conventions governing conversational interaction. These include rules for taking turns in conversations, for determining what may follow what, and for identifying the proper use of speech acts such as requests. These rules enable most conversations to flow rather easily from one person to another from one topic to another (Carroll, 1986; p.285-286).

The flow of the conversation and the topics enabled the gathering of rich data that contributed to this study's validity when the interviews were compared. To increase the chances of this occurring, the questions were asked in exactly the same manner, although not in the same order, and of each participant.

Question Clarity

Language clarity is paramount during any interaction between two or more people. It is partially because of misunderstandings that arise through miscommunication with the use of spoken language that many difficulties occur. One of life's most important skill acquisitions is the ability to use language to communicate thoughts and feelings to others (Carroll, 1986). We are social animals who require company and communication with other like-minded people for our emotional growth and psychological wellbeing.

An aspect of the interviews that needs to be considered in the generation of questions, is that at enunciation the questions will be interpreted by someone at a particular stage in life, as the answers will be interpreted by the researcher also at a particular stage in life. In essence, the data gathered during the entire process reflects but a moment in the lives of researcher and participant (Borland, 1991).

For the interviews the questions need to be simple, short, singular in focus (not double-barrelled), non-leading and positive in nature (de Vaus, 1995, & Newell, 1996). Questions are often asked, but are the answers given those which the questions were designed to elicit? In many cases there are circumstances that decrease the likelihood of obtaining an answer worthy of the question. Besides, answers are always to some extent subjective. The meaning or ambiguity of the language to a member of another

culture, the knowledge of the topic, and the confidence of the person being asked the question, could all influence the type of answer given to a researcher.

The information made available to the interview participants may prepare them for the social interaction of being interviewed, but might tempt the therapists to answer what they believe the questioner is trying to discover rather than what they actually think. The fact that they are professionals being asked about their occupation, and, moreover, that they have been trained in counselling and therapy will influence the type of information they give. All the questions asked during the interviews were open-ended and converged on or close to the interview outline (Newell, 1996).

Sample Identification

The principle of sampling is to find a representative group which has the characteristics of the larger group. "A sample which accurately reflects its population is called a representative sample" (de Vaus, 1995; p.60). The sample identification of this thesis involved acquiring a list of all the drug treatment providers in Canterbury. Then, by ascertaining the characteristics of the particular programme it was possible to obtain a representative sample from which generalisations about the wider treatment population, or staff in other centres, could be inferred.

The best way of ensuring there is equality between the potential groups for presentation in the sample would be random selection. Due to the limited number of actual treatment programmes in Canterbury, a reflection of the general population, random selection would not lead to a representative sample of programmes in Christchurch. Aotearoa's population is a communal melting pot with different cultures and groups comprising the total number of people. It would follow, then, that treatment providers such as First Nation centres for individuals with drug dependence issues, would by definition require selection regardless of whether they meet the selection criteria.

There are many other ways of selecting a sample and of testing to see if that sample is indeed representative of the wider population. Techniques such as stratified, cluster and multistage cluster sampling (Reaves, 1992), which offer sound and affirmed selection

criteria, are not applicable in this case. There is one overarching standard which must be met by the guidelines presented in Chapter 2. The sampling criteria given greater emphasis than cultural presentation is its subject: those treatment providers supported by professionals in the field of addiction. Therefore, only those advocated by specialists in the domain of addiction will be included in the sample. In addition, the sample is taken as representative of the wider population because they too have been proffered as examples of accepted treatment providers.

In essence, the sampling process was made relatively straightforward by the potential number of treatment facilities that could exist given the population of Canterbury. It was assumed that somewhere in the public arena there must be a regularly updated list of centres. Acquiring such a list or directory by approaching the experts was the first step in building a representative sample and initiating contact with the treatment providers.

Gaining Access

This research is entirely overt in that there was no need for deception at any stage from first contact and data collection, to correlation and presentation. According to Hornsby-Smith (1996), there are two main problem areas when gaining access to informants. The first is the already mentioned overt or covert style of research, and the second is the openness or accessibility of information. That is, will there be any "studying up or down" with the participants in relation to the researcher's position in society? The career positions and availability of the therapists would suggest there would be no need to study up or down. This was the case, allowing the style of research to be entirely overt, reducing potential difficulties.

The interview participants are all professionals who offer their services to the public and the topic of discussion was their chosen occupation. These ensured a relatively straightforward access process. The area of addiction treatment is not closed to the general public. However, some of the treatment centres and programmes are privately operated, which influenced the time it took to set up interviews with participants. The initiation of the entire procedure, once the sample had been identified, began with a letter of introduction.

Letter of introduction

Relevant details for sending potential interviews the letter of introduction, were taken from the list obtained from qualified specialists. It is in the interests of those treating addiction that the list is frequently updated and contains all the appropriate treatment providers. The directory proved to be an intensive guide filled with pertinent data. Consultation with experts verified that the directory is comprehensive and current.

The introductory letter, see appendix (A), contains all the information which staff at treatment centres may require to establish contact or seek affirmation of researcher suitability. The letter also mentions that the interviewer will telephone the programme in two weeks of their receiving the letter so there was an incentive for the staff to find a participant rather than simply put the letter on the "might do something about it later" shelf. The telephone call conveyed formation about the researcher: who he is and which organisation he belongs to, and how the study was being carried out and for whom (Newell, 1996).

The letter contains a brief description of the thesis topic. Because the research was entirely overt, and the potential participants are trained professionals, the main concern was that perhaps staff at the centres may not have time for an interview. It was expected that because all the participants are specialists, the amount of bias that might arise in the interview situation would be reduced.

Stereotypical Categorisation

Every person formulates and continually contributes to stereotypical categories of their environment so that they can make sense of the vast amount of available information (Atkinson *et al.* 1990). Without the use of stereotypes people would not be able to cope with their daily tasks or routines. Every piece of research is formulated and adhered to partially through emotional attachment. That is, all theory and research is inherently biased to some extent. Durkheim (1994) asserts that all scientific enquiry should be emotionally or preconceptually free. Seidman (1994; p.68) writes that Durkheim argues: "By immersing ourselves in the study of facts, we can avoid contaminating our sociological ideas with personal values." Durkheim contends it is possible not only to

distance ourselves from emotions but that we should become emotionless and thus discover sociological influential forces which affect societal institutions and offer hypotheses and explanations which we would not be able to discover otherwise.

As Seidman (1994; p.68) notes, however, "preconceptions guide our perceptions" and the formation of emotionless hypotheses and explanations is simply not possible. Interviewers and researchers can deduce and minimise their stereotypical judgements and biases by being aware of them and continually monitoring their cognitions and behaviours. I am a European male, of relatively young age, and a non-religious academic, at the post-graduate level, and am therefore susceptible to certain influential factors and forces. The propensity to build an ivory tower mentality must be continually guarded against and the underlying motivations for behaviour identified and regulated. To suggest, however, that I have no emotional connections with this thesis would be untrue. To be aware of and continually monitor the underlying influential facets and the reactions of others to me, in such situations as interviews, is essential for forward progression and learning.

Style of Interviewing

Interviewing can be conducted in many different ways, because "The normal way of differentiating types of interview is by the degree of structure imposed on its format" (Fielding, cited in Gilbert, 1996; p.135). It was decided the best form of interview would be non-standardised, unstructured and focused, because addiction professionals could be members of different cultures, of either gender and any age or religious beliefs. This would allow the greatest freedom and flexibility in deciding how to discuss the main topics which need to be covered. By giving the control of the interview to the participants it was felt that they could feel free to offer their opinions about the topic and any other issue which they felt might be relevant. In essence, the interviews should become "guided conversations" (Lofland, cited in Gilbert, 1996).

The object of the interviews was to discover what policies were advocated by the respective treatment programmes. Considering the potential abundance of philosophies, it was thought that guided conversation was the best method for eliciting relevant data. There was no possibility of conducting pilot interviews. Therefore, in order to increase

the likelihood of finding information that might be correlated with that of other treatment centres, the versatility of the focused interview was deemed the best available qualitative tool. Probes and prompts were used throughout all the interviews and attempts were made to ensure the participants believed that they were at all times in control of the interaction.

The Interview Situation

Any interview is conducted at a particular stage in each of the participants' lives: the people present have their own ongoing issues outside the interview which may have some bearing on the topics discussed. For example, there may recently have been an article in the media about the activities of a group of people with whom the interviewee identifies. This may influence the answers they provide at that time. Research suggests that the researcher should avoid being either condescending or deferential, and should be aware that age, gender, social class and religion have an impact on the interview situation and the flow of information (Fielding, 1996).

Gender Issues

The gender of the individuals involved in a social interaction such as an interview usually affects the type and amount of information provided by the interviewee (de Vaus, 1995). Feminist sociologists contend that the early theories available to researchers focused on the public domain and negated the domestic sphere. This exclusion hid women from sociologists (Cotterill, 1992). The main contention is that sociology has been primarily governed by a patriarchal view of the world and by doing so has contributed to the unequal hegemony of society. The meaning of the term gender, which may be chosen by individuals, can differ from the actual sex of the person (Robertson, 1989). For this thesis gender is, however, taken as referring to the two sexes. In the social interaction of the interview, the gender of the therapists and researcher influence the range and intensity of topics discussed and the style of the interview.

Cotterill notes that women have advocated a new method of information analysis called the "participatory model" (1992; p.594). "This model aims to produce non-hierarchical,

non-manipulative research relationships which have the potential to overcome the separation between the researcher and the researched." This involves open interaction between the participants of an interview and a combination of reciprocal sharing and emotional bonding between the interviewee and researcher. Although this task is unrealistic in the space of one interview, a free flowing reciprocal exchange of information was promoted.

Generational Aspects

The difference between generations is influential in social interactions. In contemporary culture there is an increased rate of change taking place in Western societies around the world (Giddens, 1990) which has affected and increased the gap between younger and older citizens of Aotearoa. Because of the professionalism of the two people involved the generational gap did not place a restraint upon the interviews. It was expected that the interviewer would not be interviewing anyone younger than himself, but that even if it did occur then it would not lead to any changes in the process.

Theological Variance

There was sometimes differing religious facets and underlying motivations in the interview situations. Some of the addiction programmes incorporate theological beliefs and practices in the treatment regime. The researcher was prepared to answer honestly and succinctly if asked about religious views. This did not eventuate. Again, the professionalism of the interviewees meant that this difference between participant and questioner did not impact on the flow of information.

Cultural Differences

Two of the interviewees identified with other cultures. In accordance with the ethical guideline, on occasions the researcher waited for the appropriate course of action to be made clear by the treatment providers. When there was any doubt or potential

transgression of cultural etiquette or boundaries, the interviewer asked the interviewee before continuing. There was no indication that the questioner continued at inappropriate times.

Many divergent groups and cultures together comprise our contemporary society. To be aware of all the traditional mores and norms of these would be an almost impossible task, and conversely the possibility of interviewing a member of another culture is quite high. Therefore, at all times the interviewer awaited the proper signals from the drug counsellors to continue with the interview and any further associations.

Potential Biases

Both interview attendants must guard against stereotypical judgements and cognitions, which influence the style or flow of information. A progressive fluid and open relationship needs to be initiated and maintained for the interview length if a researcher wishes to obtain relevant information and contribute to his or her own learning and professionalism. The necessity of brief interviews did not make it possible to establish such a friendship during this research process. This, however, did not mean that it was unrealistic to behave in a friendly manner. The therapists were aware that the researcher was there primarily to obtain information. As a result the interviews were relatively straightforward and pleasurable.

This meant both participants enjoyed a reciprocal, open, sharing relationship, based on the mutual sharing of information. No incentives were used or given, but it should be noted that the interviewees might have had to participate because of employer(s) and therefore may have been resentful and biased. In addition, they work there and are likely to experience some bias because of employment or familiarity issues, and they may not have felt free to divulge information that could jeopardise their employment.

Reciprocal Dynamic

Interviewees are the gatekeepers of information and, consequently, this establishes the reason the interview is occurring. Attempts were made to stimulate a reciprocal sharing

of information when questions were asked, but at all times the safety of the participants was of paramount importance. Merely to obtain the information without freely giving data if it is asked would be socially unacceptable and ethically objectionable. While the interviewer was engaged in the interview situation he was the lone representative of all sociologists and had their code of morality, in addition to the University's code of behaviour, to guide his every movement.

Data Correlation

The development of the analytic skills required to compare and analyse the information came partially from the data itself. This "approach...consists of an analytic orientation which is primarily concerned with using naturalistic data to explicate the 'methodology', the common sense knowledge and practical reasoning which underlies the in situ production and intelligibility of social actions and activities" (Heath & Luff, cited in Gilbert, 1996; p.324).

The same person conducted the interviews and attempts were made to replicate, as much as possible, the interview style and dynamic. The researcher was not, however, exactly the same person at each social engagement with different participants in varying locations. Life involves contexts and situations that necessarily change people. Each interview took place in different settings and centres that have unique influential forces.

Individual differences affect each interview: these must be acknowledged when the data are interpreted. For example, the day of the week or the number of people the interviewee has already counselled that day will have an effect on the information they provide; each interviewee will be at different stages in their lives and the researcher will be affected to some extent, by every interview. It would seem that, considering all the various influential factors, any data comparison would be extremely tenuous at best. There are, however, also similarities that make correlation plausible.

All the interviewees are professionals in the field discussing their chosen line of work. This thesis investigates the policies of treatment programmes. The centre's methodology is located beyond the individual, who may promote or deride the style of services offered

at their facility. In addition, since everything is in a state of flux the societal pressures on each facility will be similar and, therefore, generalisable to a degree.

Reaves (1992; p.129) contends that "correlation is not causation." All researchers need to identify the antecedents and measure the effect they have on the variables before discussing potential relationships between them. This is called the correlation coefficient (Hinkle *et al.* 1994). One interview participant may, for example, answer that the treatment facility has ample resources for both genders, while another person of the same centre but of the opposite gender may disagree. It could be implied, then, that the cause of the divergent answers was gender difference.

However, other influential antecedent variables could be at work. The interviewees might be at different salary levels, hierarchical positions, social cliques in the centre; they might posses different information; or they may not agree with ideologies supported management. These are a few examples, but there are many more. Ultimately the generalisability of the information obtained will be a direct result of how many of the primary antecedent variables are identified.

In Summary

The nature of the thesis topic demands that consistent attention be paid to ethics and morality. Ethical guidelines outline acceptable behaviour and cognition that effect and influence the dynamic relationship between questioner and participant. The interviewees are all specialists in an occupation of their choice. They are counsellors or therapists who are trained communicators. In addition, the vocation requires cognitive and emotional abilities which make interviewing slightly easier for the researcher than it would be if the interviewees were minors or not able to give their informed consent.

The interviewer attempted at all times to ensure that the participant was aware that they were in control of the social interaction and information they provided. Confidentiality was paramount and informed consent a requirement before progression. There was no deception at any stage of the research.

Objectivity was not feasible in a pure form, but subjectivity was reduced by the researcher incorporating awareness of its presence in the design. The purpose of the

study is not so much to provide a comprehensive/exhaustive survey of the entire field, but rather to shed some light on the treatment of addiction in Canterbury by comparing the views and beliefs of the interviewees with one another and interpreting the data and its implications.

To increase the reliability and validity of this thesis the entire process has been recorded and clearly outlined. The style of interviewing was non-focused which allowed freedom and question generation. The questions were short and clear and it is hoped that all the interviewees interpreted them similarly. Attention was given to external processes which might influence answers, their interpretation and information correlation. The data are empowered by having the primary antecedents identified and monitored. Everyone changes as they progress through life and this has important implications for this research.

Chapter 4

The Focused Interview

Introduction

This chapter introduces the results of the procedures used during the interviews, the consequences of the information gathering process and describes what happened to the researcher throughout the encounters. Initially the entire *modus operandi* for the interviews was considered to be straightforward and it was hoped that the obstacles that would arise could be surmounted by the flexibility of the guideline. This chapter outlines the descent from relatively controlled interviews to the development of spontaneity and unexpected events beyond the researcher's control.

The central theme presented here is the transcription of the actual events as they unfolded during the interviews of staff members at drug treatment centres. The entire sequence from the first interview to the last increased the skills of the researcher exponentially. The initial stages began at a rather subdued and comfortable pace. Quite rapidly, however, the interviews became a self-determining sequence that seemed to take on a life of its own, only becoming calmer or even sedate towards the end. The amount of flexibility incorporated in the research design fell short of coping with the reality of interviewing staff members at treatment centres.

Due to the inherent difficulties present in the representation of any social discourse, it must be noted that between the utterance of the information and the presented form here, there has been data degradation. To assume that there has not would be unrealistic. In addition, although every attempt was made to present the data accurately, a detailed transcription of every word would take too long. Therefore, each interview is presented in a condensed form and only selected quotes have been included in the text.

The transcription of the spoken word loses meaning from utterance to the written word when it is no longer associated with all the other forms of language, such as bodily or facial movements. Consequently, some of the non-verbal interactions of the encounters have been described to provide a clearer impression of the interviews. Moreover, some of the equipment that was to be used at every encounter could not be utilised partially due to events beyond the control of the researcher. The entire procedure produced a

wealth of information that has increased my understanding of the intricacies of social interaction beyond what I began this process with.

The chapter begins with a brief discussion of the interview question sequence and describes the reasons for the presentation of the documents at the beginning of each interview. A section outlining the location and consequences of obtaining the directory of contemporary drug treatment providers in Christchurch follows this. Then the discussion turns to the selection of the representative sample made possible by the list and the eventual exclusions and why certain treatment providers were not sent letters of introduction, which is outlined in the next segment.

A brief description of the initial contact, and in some cases ongoing interlocution, is followed by abridged interview transcriptions describing the interactions. This chapter is concluded with an epilogue and summary.

Question Sequence

The presentation of the relevant information to each interviewee is pivotal in establishing or setting the stage for the direction of the conversation. After greeting the participants the documents such as interview topics were provided at the beginning because the researcher surmised it would set the scene and guide the discussions. This was instead of sending the data with the introductory letter, which would have possibly contributed to its being ignored. One of the documents presented to the interviewees was titled "Interview Information Guideline" (see appendix B). In the guideline there is a brief list of core topics and another of interview subtopics. The latter describes topics that were discussed in the interviews.

The questions are an indication of the subgroup(s) addicts might belong to and are present because they are a reflection of certain social divisions in contemporary society. Each interviewee was asked about their centre's treatment policies regarding clients' age, gender (including sexual orientation), cultural identity, specific needs (such as co-morbidity), and the programme's resources and funding. There was, however, no rigidity in the order the questions were asked during the interactions. The questions were asked each time, but posed to fit into the dialog as part of the focused flowing style of

interviewing. Having established the questions, the first task in obtaining information was to locate the list or directory from the professionals.

The Directory of Contemporary Addiction Treatment Centres

On 14 February the first e-mail was sent to an individual at the "National Centre for Treatment Development" (NCTD) for Alcohol, Drugs and Addiction, in the Department of Psychological Medicine, Christchurch. Another e-mail was sent to the Alcohol Advisory Council of Aotearoa (ALAC) to the Manager of the Southern Region, also in Christchurch. This was the first contact with specialists in the domain and both individuals proved invaluable. Relevant topic information came from NCTD while the directory for treatment centres was, and still can be, located at the ALAC office.

At the ALAC office, maintained by two extremely helpful staff members, there also is a small library, which contains texts and information of every description about or relating to the pandemic malady of addiction and its treatment in Aotearoa and, specifically, in Canterbury. This thesis would not have been possible without the two wonderful women in the ALAC office.

The Representative Sample

The directory itself lists the nation's treatment centres and was not a loanable text. An employee at ALAC kindly photocopied the relevant section and provided a wealth of pertinent information. The data in the directory is clearly labelled under three distinct headings for each centre. These are:

1) *Access Information,* which refers to the location, contact numbers and names, hours of availability, the language and physical access details.

2) *Client/Staff Information* lists the services, special clients' needs and matching to staff.

3) *Service Information* outlines the treatment's philosophy, models and focus, requirements such as abstinence, assessment capabilities,

detox potential, residential facilities, counselling, aftercare and resource access.

The directory is a comprehensive description of each agency and it contained enough information for the generation of a representative sample. There are eleven treatment programmes listed and on the basis of such an extensive presentation of data it was decided to send introductory letters to eight of the agencies. Several facilities mentioned in the directory were not included in the sample; the reasons they were not are discussed shortly. A well-known treatment programme was also not mentioned in the section of the photocopied directory—Queen Mary Hospital (QMH) in Hanmer Springs—because it is not in the Christchurch area. This was included in the sample because it is one of the most well-known treatment centres in the country and has one of the largest facilities.

There are three programmes not included in the representative sample. Selection for the sample is based on criteria such as residential facilities, duration of treatment, services offered and specialised staff, such as professional and cultural availability.

Selection Criteria and Sample Exclusions

The first programme outlined in the directory but not included in the sample is the Alcohol Helpline. The Alcohol Helpline offers addicts telephone counselling, which is an invaluable service but not one that is comprehensive enough to be included. A treatment facility is perceived to be a centre with a physical location where addicts can reside (albeit briefly), receive assessment, client matching to treatment, and therapy, for an inclusive period of time if required.

The second agency not included in the sample is the Thorpe House Detoxification Service. This centre offers assessment, although only psychologically, and does have residential facilities for addicts seeking help. It nearly fits all of the selection criteria, but the length of stay is extremely short and it is a service offered to addicts seeking immediate detoxification rather than abstinence in the long term. The treatment includes residence and intensive short-term therapy for detoxification purposes, but educational, motivational, and behavioural modification for their addiction occurs in one of the other

programmes. The agency plays an invaluable role in the array of Christchurch treatment facilities for addiction, but because of its specific detoxification focus and design it does not fit the selection criteria.

The third treatment centre not included in the sample is the Christchurch Methadone Programme. This service offers an extensive range of therapy, counselling and educational options. It has professional staff providing an essential link in the range of treatments available to addicts. Part of the long-term treatment they provide involves dispensing synthetic heroin, Methadone, from which the addicts are slowly weaned. The service does not, however, have any residential facilities, nor does it offer culturally distinctive or gender germane treatment for subgroups of addicts and is therefore excluded from the sample.

The Introductory Letters

The sample obtained from the directory totalled eight and comprised of nearly all of the treatment programmes in Christchurch, which amounted to nine including QMH in North Canterbury. The treatment centres in the representative sample are:

1) 198 Youth Health Centre

2) Alcohol and Drug Service – Christchurch City Mission

3) Community Alcohol and Drug Service

4) Nova Trust

5) Odyssey House

6) Pacific Island Evaluation Inc – Alcohol and Drug Resource Service Centre

7) Te Rito Arahi – Māori Alcohol and Drug Resource Centre

8) The Salvation Army Bridge Addiction Centre

9) Queen Mary Hospital

Having established the representative sample, each of the nine facilities was sent an introductory letter.

Initial Contact

During the same week that the letters were sent the researcher received two phone calls and a letter returned to sender. The City Mission stipulated that before any further contact could be possible between the centre and researcher, it required a copy of the ethics form submitted to the Ethics Committee earlier in the year. A letter outlining the Committee's affirmation and another letter providing more information were sent to The City Mission at the beginning of the following week.

The second phone call was from The Bridge Programme and mentioned that the researcher should ring a particular staff member. The returned letter suggested that the facility had moved and required investigative skills to establish a new address to which the next introductory letter could be sent. Unfortunately, the directory was not as up-to-date as originally anticipated: it contained one wrong address. By the beginning of April, the correct address of the missing centre had been identified. Over the end of March and beginning of April numerous telephone conversations took place with all the letter recipients. On 18 April the first interview was recorded.

The First Interview

The first centre to offer an appointment with a member of the staff was Te Rito Arahi. This facility offers culturally sensitive services to members of the Māori community, and other individuals of any culture seeking treatment. H arrived after several minutes and after a quick introduction, involving a handshake in European fashion, led the way into his office and offered the questioner a seat.

Once seated the interviewer gave H the information sheet (see Appendix C), consent form, interview information guideline (see appendix B), and asked if he had a copy of the introductory letter. He replied he did and quickly scanned the documents. The researcher then asked if it was acceptable to record the interview. H agreed to be

recorded, signed the consent form, and from the beginning took control of the entire interaction. A brief summary of the interview is offered next, but throughout it might be of interest to note that it took all the skills of the questioner to keep the interview focused and insert occasional questions where possible.

H clearly stated from the onset that European treatment of Māori addicts was not holistic enough and that this facility existed because there is a need for it. "Needs of the Māori were not being addressed appropriately or culturally. This is an agency set up by Māori for Māori." The need for the Māori to heal in a culturally appropriate facility, with culturally sensitive counsellors and treatment, was and still is not being met by the European dominated medical community of Aotearoa.

The centre, according to H, does not turn anyone with substance dependence issues away and offers appropriate treatment for those who choose to be helped in this manner. The programme provides assessment, counselling and "a drop in" facility. H stated that "substance abuse is a symptom of deeper problems" and that several of the trained staff and many of the volunteers are in recovery (recovery is associated with the twelve-step programmes and means total abstinence from all licit or illicit severe psychotropic substances).

The facility receives funding, but not enough, from the Health Funding Authority (HFA), and they have to expand time and energy to sell themselves and their work to the public in the search for programme sponsors. The centre liaises with the legal system and other drug treatment services, such as the Taha Māori programme at QMH. The agency is staffed by five therapists and receives help from other professionals for free. The facility offers addicts educational, health, motivational and behavioural courses.

Te Rito Arahi has separate programmes for women, according to H, because some of the women have issues with men. The centre treats many self-referrals and is continually monitored and scrutinised by everyone. This is good, noted H, because it keeps everyone on his or her toes and means that they can apply for more funding.

The facility offers separate counselling for individuals who identify as members of the homosexual community and they also have programmes for youth. "The centre is a place where anyone can come in for a cup of tea and relax or discuss their problems with someone who will listen. We offer a holistic approach that emphasises the

connections between emotional, spiritual and psychical needs, inside and outside influential forces upon the body."

"The Pākehā lack cultural understanding. Mainstream addiction treatment does not address the full requirements of Māori healing and health needs. A Māori has a connection with the whole environment." The centre was established in 1985 by Māori people who felt that they were not being treated in a manner they desired and required. The staff at the centre plan to expand the therapeutic options and educational facilities, and hope to provide a holistic approach to the treatment of addiction in the future.

The interview took approximately an hour and was recorded. Throughout the entire process H was in control of the flow and topics covered during the exchange, and conveyed his message clearly and concisely. The experience left the researcher wondering if all the interviews would run as smoothly and efficiently. It also left the questioner feeling grateful for the experience of interviewing someone like H in a wonderful centre. Earlier in the interview H had stated that he had spent some time in the army and liked to ensure operations ran smoothly. H provided excellent information in a loquacious manner and left the researcher hoping that the rest of the data gathering process would flow similarly.

The Second Interview

On 26 April, despite attempts to avoid it, there were two interviews on the same day. The interviewer attempted to schedule one interview per day to limit the interference and thereby reduce potential information deterioration. The opportunity to interview two people on the same day, however, provided a series of experiences that resulted in the acquisition of skills that would not have occurred otherwise. The first interview of the day was with an individual at The Bridge Programme, which is staffed and maintained by the Salvation Army.

Participant B welcomed the researcher into the facility with a handshake and introduction. The two then moved into an empty conference room with several chairs and a table. After sitting down the researcher gave B the information sheet, consent form and interview topic guideline, and asked if he had seen the introductory letter, which he

replied he had. After reading all the information, B signed the consent form. The questioner also asked B if it was all right to record the interaction. B replied it was and offered the interviewer a place to put the Dictaphone. During the interview B wore the Salvation Army uniform and was open and reciprocal in sharing information when requested.

The first topic of discussion was that there are, in Christchurch, four main assessment gatekeepers. An assessment gatekeeper is an organisation that is responsible for the initial contact, assessment and client treatment matching process. This stage is crucial for the potential successful treatment offered to addicts. If the initial contact is not affirmative, the assessment is wrong, or the client is not matched to the most effective treatment then this drastically reduces the chances of goal attainment or long-term recovery, according to B. The four assessment gatekeepers are:

1) Community Alcohol and Drug Service (CADS)

2) Christchurch City Mission Alcohol and Drug Service

3) The Salvation Army Bridge Addiction Centre

4) Te Rito Arahi Māori Alcohol and Drug Resource Centre

The Bridge programme lasts for six to eight weeks, but the centre has various facilities such as a half-way house along Bealey Avenue where an addict may reside for up to twelve months, according to B. In addition, they have a separate wing of the main complex dedicated to women. The women are able to stay in locked rooms and there are plans to increase the facilities for them in the near future. There are, however, no services for people under the age of eighteen. The funding for the centre comes from the HFA and other means such as donations to the Salvation Army.

The agency provides group counselling and long-term individual therapy possibilities. The primary policy is the twelve-step programme which is underlaid by the harm-reduction principle. In all treatments for addicts the initial concern is harm-reduction, which may vary in its application and maintenance. The main goal of the programme is maintained long-term abstinence from all severe psychoactive addictive substances. Abstinence is a prerequisite for addicts to attend the centre and receive treatment. The

Bridge offers a detox facility that can be arranged prior to treatment for addicts requiring help in achieving abstinence before joining the programme.

The Salvation Army is, however, considering admitting Methadone clients to the centre, which would require a change to their entry criteria. The facility provides a residence for affiliated twelve-step programmes to have meetings, and staff support the eclectic use of all the twelve-step guidelines. Rational Recovery, for example, concentrates upon the cognition of addicts while Alcoholics and Narcotics Anonymous advocate a spiritual journey of recovery. B stated that although the clients are required to attend a Christian based meeting once a week, the theological beliefs of the staff are not presented as a basis of treatment. The spiritual beliefs of the staff, however, contribute to the underlying policies and consequential treatment of the addicts. B stated that the treatment involved "an essential spiritual walk."

The programme places people into Taha Māori at QMH, Te Rito Arahi and Pacific Island Evaluation Inc. The centre is primarily Pākehā in orientation but is attempting to increase its liaison with the Māori community and improve its cultural awareness. The programme provides after-care with on-going counselling and organises social occasions for clients who have graduated. When an addict presents with severe co-morbidity, according to B, they are sent to CADS, which has a psychiatrist and which verifies assessment of the psychological state and physiological condition of clients with local general medical practitioners.

Again the interview lasted for an hour and from the onset went smoothly and involved the reciprocal sharing of information between interviewee and questioner. The interviewer left the centre feeling gratitude at having had the opportunity to converse with one of the senior staff members of the programme and began to realise how extremely busy the staff are at drug treatment centres. After the interview, however, the researcher was not able to go back to the office but had to remain in the city for the second interview. Consequently the transcription did not occur until later in the day and some information may have been lost because of the delay.

The Third Interview

The third interview took place at Pacific Island Evaluation Inc., a community based alcohol and drug service exclusively for Pacific Island people. It was this centre that had moved and required some investigation as to the actual location of the facility. Another letter of introduction had been sent, but at the time of the interview there was some uncertainty whether it had arrived. As a precaution the interviewer brought another introductory letter along with the information, consent and interview topic forms.

Participant C walked through a door and greeted the interviewer and guided him towards his office. They sat in their respective seats, with a desk in the middle, and C was handed the relevant documents including the letter of introduction. He read them and signed the consent form, which he handed back to the interviewer. The questioner asked C if it was all right to record the conversation, to which C agreed, and the Dictaphone was placed on the desk.

The first conversational topic was the centre's exclusivity, focusing on why it only catered for Pacific Island people. C stated that "Pacific Island people identify with other Pacific Island people better because they have the same experiences." It is a preference for people from the Islands, noted C, to be treated by other Islanders because they find it easier to discuss their problems with members of the same culture.

The programme itself began in 1990 as a result of the successful establishment of Te Rito Arahi, and there was and is a need for the treatment of Islanders by other Islanders which is not being catered for by the mainstream addiction centres. According to C, Pacific Island people have increased chances of successful treatment if they receive therapy from members of their own culture. Due to the exclusiveness of the clients, funding was hard to obtain in the beginning, but it is getting easier to find. The bulk of the funding for the facility comes from the HFA, but there are other available sponsors and numerous funding possibilities for the centre.

The City Mission conducts most of the client assessment, but the facility is capable of conducting its own assessment, counselling and day programmes. At the moment, according to C, the programme functions like a halfway house, catering to addicts and members of their immediate and extended families. In the future, however, they want to

expand the centre by building more facilities, establishing a residential programme and employing more qualified staff.

C stated that many Pacific Island people abuse alcohol but are not dependent on it. "Pacific Island people see the rewards mainstream society gives to many Palangi and instead, to divert their thoughts, Islanders abuse alcohol in the weekends." This is especially true of the Pacific Island youth born into European culture. "The youth are not born into Island culture and seem to have a great deal of spare time, and many spend it drinking, which they really seem to enjoy." The facility provides individual and group counselling for heterosexual males and females who identify as being Samoan, Cook Island Māori, Niuen, Tongan, or Fijian.

The centre provides treatment for adolescents, children and their extended families. The central treatment methodology is motivational interviewing which focuses on a holistic approach, according to C. The fundamental goal of the agency's policy is long-term drug abstinence and early intervention is a primary focus. The agency offers community reinforcement, social skills and relapse prevention programmes. For the future, C noted that he would like to see an extension of the facility to provide residential beds, and larger quarters than present. There is a need for more work to be conducted in all areas of drug treatment for Pacific Island people of all ages and this requires more staff and increased space. C indicated that the programme was currently too small and would be expanded soon.

The interview lasted for approximately three-quarters of an hour and finished with a handshake. C wished the interviewer good luck with his work and hoped that he was successful in his endeavours. The researcher was left hoping that it would be possible to convey all the information provided by C, but was apprehensive about the language interpretation. The interview did not flow as smoothly as planned, partially because of the language difficulties, and left the questioner wondering what went wrong and might be improved next time. Occasionally, throughout the interaction, the researcher asked C to repeat what he had said because it was not clear to him. This may have influenced the overall feeling that the reciprocal flow of information could have been better.

The researcher then journeyed home to his office and quickly transcribed as much as possible of both interviews. The second interview used the second side of the tape in the

Dictaphone and after transcription this was wiped by placing the device recording in a quiet area for the duration of the tape. As before, once the transcription was completed the hand-written notes were destroyed. The next interview cleared the recording of the last.

The Fourth Interview

As part of the process to establish an interview time with the centres, several had not provided a date by this stage because of absences of the management or senior staff or other circumstantial factors. During a phone call to establish a time for an interview with a staff member at 198 Youth Health Centre, the unexpected occurred. Rather than ascertain a time for an interview the staff member at the centre wished to conduct the interview over the phone. Initially the researcher attempted to dissuade the participant because it was against protocol and the interviewee needed to have read the information and interview topic documents before he could sign the consent form and begin the interview. Suggesting these reasons to the participant resulted in his proposing that the researcher simply send the information later and he would sign it and return the consent form to the appropriate address in the introductory letter. Having established that the participant knew what was required, that he could cease at any time he wanted and in that event data gathered so far would be destroyed, the interview commenced.

An Impromptu Phone Interview

Of primary concern in the treatment of clients, for the 198 Youth Health Programme, is the immediate reduction of harm. For participant D this involved any intervention that resulted in positive improvements for the clients. The staff at the centre—the therapists and counsellors—advocate either total abstinence or controlled use depending on the client, the client's substance(s) of choice, and other factors such as outside support and the individual philosophy of the staff member. According to D, the entire process of the treatment of adolescents or young adults (the centre only offers its services to people aged between ten to twenty five years of age) is compounded by the problematic experiences and feelings most people encounter during this stage of life. That is, the

staff need to consider the history of the client but also try to ascertain whether adolescent stages and rebellion issues exacerbate the behaviour. In order to do this they need, at presentation of the behaviour, to compare it to the different forms and consequences of addiction. Then the staff decide if the behaviour is atypical or cyclical rebellion, or involves cognitive health issues. To increase the likelihood of successful outcomes and goal attainment, the centre employs a multidisciplinary team that D felt was better for assessment, treatment and comparison of philosophies between staff members.

The facility does not have an induction stage but "treats adolescents or young adults straight off the street" or clients referred by their general practitioners. The treatment of individuals from the street results in working with intoxicated people. The agency emphasises the socioenvironmental approach that focuses on holistic treatment of the client. The staff, according to D, promote self-awareness and motivational behaviour. The centre refers individuals to the youth programme at Odyssey House and other applicable residential agencies. If further assessment is required the agency refers the addict to the appropriate facility.

Of primary importance, according to D, is that throughout the entire relationship between staff and client, it is recognised that there is a tension between addiction and stages in a young person's life. Consequently, there needs to be some amount of manoeuvrability in the treatment of adolescent individuals who present with drug dependent issues. Therefore, in many cases any change in behaviour which results in harm reduction is seen as positive by staff.

According to D, the centre provides treatment for lesbians and gay males, intravenous drug users, sex industry workers, transients and homeless, and those involved with the legal system. The facility receives funding from the HFA, but requires more resources to offer a more comprehensive service. The agency promotes brief interventions, self-help and support group meetings, and individual counselling. The policies are primarily harm reduction based, but also incorporate cognitive behavioural therapy, relapse prevention, twelve-step guidelines, and the socioenvironmental holistic model. The centre employs a multidisciplinary team of professionals because it provides a good coverage and reflects the requirements of clients, according to D.

At the end of the interview D was thanked for his participation and asked to sign and return the consent form at his convenience when it arrived in the mail. He said that he would and thanked the interviewer for the opportunity to discuss the agency's policies. With this the interview was finished. The interview lasted approximately half an hour and seemed to proceed relatively smoothly. An interview over the phone was new to the researcher who began a little nonplussed, but was quickly put at ease by D. The overall impression, again, left the questioner feeling grateful for the opportunity to interview individuals who coped with extremely heavy work loads and yet still found time to help him in his endeavour. D signed and returned the consent form. It was not possible to record the interview and this is reflected in the information presented in the "Results Chapter."

A Preliminary Interview

This interview was of an unexpected nature and not one that was envisaged as needed. In this interaction the researcher expected to provide clarification about the research project; instead the centre management conducted a preliminary assessment of the researcher. This meeting occurred because a senior management official at The City Mission required clarification about the topic and style of interview. In essence, the social interaction occurred because a gatekeeper needed to assess the researcher, and research requirements, before permission could be granted to interview a member of the staff.

The meeting took place in her office and lasted for fifteen minutes. Throughout this time she was in control of the entire situation and the interviewer became the interviewee. She asked questions to which the researcher replied as efficiently as possible. During the interview she fielded several phone calls and questions from her secretary, in addition to having other people waiting to see her. She was extremely proficient and busy in her work and treated the researcher with the utmost professionalism during the interview.

She asked to see the sheets of information, which were offered, and read and photocopied the data before giving it back to the questioner. Ironically, she changed and signed the consent form for the participant and clearly stated that they, The City Mission,

would comply with the interview request. The researcher thanked her for the opportunity to interview a staff member and for her time. There was no need to record the interview and nor were any notes taken. The researcher was left with the impression that her office was the hub of the organisation and she is extremely efficient in her work.

The Fifth Interview

The researcher was met in the reception area, by participant E, and invited to his office. After being seated the researcher asked if it was all right that the interview was recorded. E replied that it was fine and the questioner handed him the documents, minus the already signed consent form, and mentioned that the consent form had already been signed on his behalf. After establishing that this was all right with E, and the reading of the information was completed, it was reiterated by the questioner that E had the option to cease at any stage and that all the information would be wiped if that was his wish. He replied that he understood and the interview commenced.

E began by stating that the Christchurch City Mission conducts assessment and intervention, treats outpatients, has a detoxification facility and promotes family support through education, provides referrals to other services and has a separate women's facility. The policy of the agency is primarily client-centred and focuses on harm reduction. Its array of treatments is eclectic in nature, according to E, and treats individuals of all ages. This includes gay clients but they present with additional difficulties. The facility tries to be gay-friendly but helping people with gender or sexual preferences different to the majority entails additional issues that compound addiction treatment. The agency, noted E, works with differences.

The centre is religion based, but not in its treatment of clients. Many of the employees at the facility are social workers and they tend to employ the CADS medical holistic approach. Post-treatment is offered and the facility also provides clothing, furniture, budgeting advice, a inner city night shelter, mobile assessment and Hebron Child and Family Service support. If a person presents with severe co-morbidity then they are referred to the psychiatrist at CADS. The agency also has a health clinic and a visiting nurse. "During treatment clients set their own goals and receive help identifying issues."

The addict is then able to identify the best outcome and clarity of achievement. The staff use Doug Sellman's comprehensive treatment diagnosis model.

Over the course of time E has seen the shift from the biopsychological to the socioenvironmental model become more pronounced. There is, noted E, growing evidence to suggest that the treatment of addicts is enhanced with an approach which is more eclectic in nature and holistic in scope. According to E, Healthlink South is still disease focused in nature and has only recently begun to advocate the newer socioenvironmental model. The City Mission, like other drug treatment centres, receives most of its funding from the HFA, which promotes competition for clients between the agencies. E mentioned that this competition was co-operative and resulted in a sharing of information and resources between the facilities which ultimately improved the chances of offering successful treatment to individuals seeking help to overcome problems as a result of drug dependence.

Throughout the entire process E seemed to be comfortable with the interview and asked questions which were openly answered by the interviewer without hesitation. The interview finished with a handshake and E offered his support if any was required later in this research. The questioner thanked him for his time and energy and assured him of further contact if it was needed. In the last chapter this interview and consent issues are explored in further detail.

The Sixth Interview

The Nova Lodge is the second to last service in the information gathering stage of this thesis. The participant, who was in the middle of sorting out issues with several residents, met the researcher at the door. She guided the questioner into her office, after reaching a conclusion with the residents, and read the offered documents. She signed the consent form and agreed to be recorded. After switching on the Dictaphone and ensuring it was operating, the interview began.

The addicts, according to F, come from almost all of Aotearoa. Only the northern reaches of this country places individuals in another facility in the North Island. The residents at the centre were all referred by "staff at alcohol and drug centres, clinicians

or judges" enforcing a legal provision or sentence placement. The external gatekeepers performed the assessment and, therefore, the agency did not have to concern itself with initial appraisal or client treatment matching.

In the facility there is one "fully qualified counsellor and three part-timers." The qualified counsellor had successfully completed an Alcohol and Drug Counselling degree. The entire treatment is living skills focused. The agency operates a six-month work therapy-based programme, which provides residents with an opportunity to keep busy and learn new skills that they can take back into the community. The centre is known as "the revolving door" facility because it provides a place for people to learn new skills with which they can change their behavioural pattern of binge drinking or drug taking during their spare time in society. A person "in recovery" established the agency and believed that busy hands and minds would not take up that first drink or drug as quickly as idle ones. "The programme is recognised for the learning of skills which occupy time otherwise spent drinking."

Individuals can be committed here by themselves, through a drug treatment programme, or by the courts when judges, such as two medical practitioners, place them there. The facility, however, according to F, does not accept individuals who use intravenously (junkies) or oral drugs "pill poppers." "The centre accepts people from the thirty and up age bracket, which means it is not for the young." F stated that dual diagnosis or "co-morbidity is the norm now" which has changed from the past. The programme is always open to those who are compliant with the rules and regulations and they are "welcome back at any time." Wider society is perceived to be harder to live in than the centre and part of the facility has begun to operate like a halfway house. Some of the programme's residents are now boarders who have remained drug free for a period of time and are therefore eligible to become staff and help with other clients and daily duties.

There are a small number of women who are not segregated, but stay in separate sleeping quarters. The centre runs study groups with a diverse range of topics such as: Māori issues, religious teachings and history, and literacy and numeracy classes. If an addict needs or requires specialised counselling then he or she must find it outside of the agency and pay for it from her or his own expenses. The programme does not turn away many potential clients and accepts those rejected by other treatment centres.

Consequently, they have individuals with Korsakoff's Syndrome, and other forms of dementia at the facility. Psychological dementia maladies may be caused or exacerbated by chronic alcoholic behaviour. Indeed, Korsakoff's Syndrome is the consequence of damage to the cortex by excessive alcohol consumption usually resulting in total amnesia.

F mentioned that one client had left earlier in the year to binge drink for a period of nearly half a year. When he left the client was relatively normal in his behaviour, insofar as an alcoholic is part of a larger normal group at the centre. Now that client has become a patient requiring twenty-four hour care due to Korsakoff's Syndrome. He remains bedridden and will never again live life as a functioning member of society. "He is a good lesson to the others who can now see what might happen if they continue to binge drink."

The interview lasted for approximately an hour and left the interviewer feeling grateful for the experience. Again the participant was an extremely busy woman who took time out of her duties to discuss the programmes policies and treatment methods with the researcher. She freely gave her time and contributed to the growing amazement the researcher felt at the professionals who work in the field of addiction. They are all very busy people who offered to discuss their chosen career and place of work with the questioner.

The Seventh Interview

The last interview took place with a staff member at the Community Alcohol and Drug Service (CADS). After waiting in reception the researcher was met and greeted by a staff member who guided him back to his office. Again the initial greeting was in the European custom and both people were seated in chairs facing each other beside a desk. The interviewee received and read the documentation and signed the consent form. After asking if it was all right to record the interview, and receiving an affirmative reply, the questioner placed the Dictaphone on a small coffee table to the side of the participant. The Dictaphone did not, however, actually record anything. It was discovered after the interview that although the record buttons were depressed, the machine had not taped the conversation. The researcher had assumed that because the Dictaphone

had worked every other time it would do so again and failed to check it during the interview: another valuable lesson learned during this process. The information during the conversation was noted with a pen and paper, as every other interview had been, and this was the only information from which transcription could be made. The failure to tape the interaction has resulted in a loss of information. The interaction itself, however, flowed smoothly and quickly.

The participant at CADS made the researcher feel extremely comfortable and was a fount of information. The interview began with a discussion about assessment and referral. He mentioned that the centre accepted referrals from anyone and anywhere, such as the justice department, health department, local general practitioners, other centres and even self-referrals. The facility treats those addicts in the moderate to severe range of the malady. G mentioned that the staff prefer clients to present whilst still using and thereby establishing a point of reference for both parties. A person using substance(s), which may be noted and compared, presents with a baseline from which future changes to behaviour may be evaluated. In addition, it is preferred because enforcing abstinence before treatment was unrealistic for many people. According to G, enforced abstinence creates resistance and will result in fewer people presenting for treatment.

The initial contact at the agency occurs with the intake co-ordinator, who matches the client to the appropriate service. Treatment matching occurs with the addict's consent and there are usually no overt gender issues at this stage, according to G. He pointed out, however, research indicates that women feel more comfortable with female staff members and are usually more forthcoming with information which may effect their rate of goal attainment during therapy. This was also true of people who identified as being members of other cultures. Clients presenting with diverse cultural affiliations resulted in a diversity of staff at the centre. The agency is adult-orientated but has facilities and specialised staff for minors.

One of the primary policies of the agency is that no one is required to present with total abstinence. The problems of the addicts are the central issue, which the staff identify. Although there are inherent problems, the personnel are getting better at identification, then work towards harm reduction. There are many definitional aspects of identification which require extensive research so that a more comprehensive understanding is

reached about their influences on the physiological and psychological behaviour of people suffering from addiction to drugs. Severe psychological conditions, such as the presentation of co-morbidity, require more intensive treatment and resources. Co-morbidity does not fit into the biopsychological model of drug treatment, which was one reason it has been perceived to be extremely resistant to change. In addition, there is still confusion about mood, disability and psychological disorders. In the past the categorisation of these disorders was easier for the staff at centres, but decreased the actual therapy potential for the clients.

In contemporary society there is direct competition between treatment facilities, according to G, because they are all underfunded. The bulk of the funding for all the agencies comes from the HFA, and they provide it on the number of clients treated at the respective facilities. Centres competing for funding from a limited resource provider such as the HFA have staff devoting time and energy attempting to obtain more funding which could be contributed to increasing treatment potential.

CADS provides a brief treatment with a multidisciplinary team referring addicts on to appropriate centres. The staff at CADS use case management plans for clients with an eclectic approach to counselling. This ranges from promoting self-help to research-based practice, pharmacology, narrative therapy, relapse prevention, motivational therapy, twelve-step programmes and cognitive behaviour modification therapy. Slight improvements are perceived to be good and any harm reduction is a step in the right direction.

At the completion of the interview G was thanked for his participation and it is hoped that he experienced the reciprocal sharing of information as positive. Unfortunately, information was lost because of the researcher's failure to operate the Dictaphone successfully. The last recording of the previous interview was wiped by recording nothing for an hour and the notes taken during the interview, as before, were destroyed after the completion of transcription. On the successful presentation of this thesis the data on the computer's hard-drive shall be deleted in accordance with the guidelines provided by the Ethics Committee. Two treatment programmes declined to take part in the interviewing process.

Epilogue

All the interviewees, apart from the staff member at The City Mission and the phone participant, signed the consent form at the beginning of the interview. The phone participant signed the consent form at a later date and posted it back to the University—it is presumed it was the person on the phone who signed the consent form. There is no way of verifying who the person on the other end of the phone was and it is assumed he and the signature are one and the same. All the participants were initially asked if it was all right to record the interview, except the phone interviewee and The City Mission management gatekeeper.

During the time it took to interview all of the participants, QMH and Odyssey House, after repeated attempts to gain access, declined to be a part of this research. QMH voted on the matter at an internal council meeting at which, after deliberation, it was decided that it would not be possible for the researcher to interview a member of their staff. There could be numerous reasons for this decision, but any speculation concerning this matter would be mere conjecture.

Odyssey House underwent a change of director, which may have influenced the re-establishment of an interview time. There was a misunderstanding about the date and time of the interview. My diary indicated Tuesday instead of Monday and, consequently, I missed the interview appointment. Messages, with apologies, were left after the missed appointment but no further contact was established and the matter was left at that because of time constraints. It is with the deepest regret that I missed the appointment at Odyssey House as it plays a pivotal role among the treatment centres in Canterbury. Again, I learned an extremely valuable lesson, one that I will never forget.

Summary

The interviewing process started off as envisaged but quickly became unpredictable as it gathered momentum. In the beginning, before any participant had been interviewed it was decided that each interview would start with the presentation of the relevant documentation. This established a reference point from which the interviews could progress through the topics, guided by the researcher with probes and questions.

The location of the directory was straightforward and contained a wealth of information. This data resulted in the selection of the representative sample, and using the selection criteria as a guide, three centres were not invited to participate. Equipped with the addresses obtained from the directory, the researcher sent introductory letters and the initial contact began. For some of the programmes the process of attempting to establish interview appointments continued throughout four months.

The first interview was straightforward and the researcher hoped it would set the stage for the entire exercise. The participant at Te Rito Arahi was a model interviewee and seemed to enjoy the discourse. The first obstacle was the scheduling of two interviews on the same day and necessitated some improvisation on the part of the researcher. This was successful with minimal data loss. At times, however, life can be unpredictable and spontaneous. The next interview took place over the phone and presented the researcher with a plethora of obstacles. The interview could not be recorded and yielded less information than others, and required some circumnavigation of the standard procedure by the questioner.

The following interview was a preliminary for the actual interview and the interviewer became the interviewee. This brief encounter indicated the enormous workload drug centre staff are under. The only complication arose when the senior staff member signed the consent form on behalf of the participant. This was discussed with the participant and the process did not proceed until it was clearly established that he could stop at any stage if he wanted to and the information gathered so far would be destroyed. There are ethical issues here that are explored in the last chapter.

Two treatment centres declined to take part in the research. Queen Mary Hospital and Odyssey House did not provide a staff member as a participant and their absence has diminished the generalisability of information contained in this thesis. There could be numerous reasons why these two facilities did not wish to take part, such as workloads and not being able to schedule the time required. Both programmes occupy pivotal roles in the treatment of addiction in Canterbury and it is hoped that they, and the centres that took part in the research, continue to provide an outstanding service to the region for many years—or until the need for their services is no longer required, which at this stage is becoming ever more remote. In the next chapter results obtained during the interviews will be correlated and presented.

Chapter 5

Results of the Interviews

Introduction

This chapter presents the highlights of the interviews. Rather than continue the format of the previous chapter by outlining each individual participant's contribution, all the information is separated into the relevant topic sections. This chapter, then, is a comparison of the main points that arose in the interviews with the seven staff members from the various centres. Again, it must be noted that the following information is a collection of the opinions of the seven interviewees about the policies and methodologies adhered to in each facility where the informant works. The data may not represent the actual policies or methodologies of the respective programmes, but does offer a comparison between the seven participants and, when collected together, with the literature.

It is argued that the comparison of the information provided by the interviewees presents a picture, albeit momentarily, of the addiction treatment offered to addicts in Christchurch. Throughout the chapter it must also be taken into consideration that the data obtained from the interviews has already become dated to an extent, because the information gathering process ended approximately six months ago. In essence, this thesis is a snapshot of seven drug treatment centres and the methodologies advocated by the majority of addiction treatment programmes in Christchurch at that time. There is some overlapping of material due to the nature of the subject. Every aspect of the treatment of addiction is closely interrelated with other influential facets and to discuss any in isolation would not be possible.

The layout of this chapter does not sequentially follow the list of the subtopics in the interview guideline form. Unlike the focused or unstructured style of interview, this chapter offers the descriptions of the subtopics in reference to each other rather than in the random order in which they were discussed. The design of the chapter was guided by the interdependence of the material.

The first section called "Client Assessment and Treatment Matching" discusses the initial contact between health provider and client. Following this are sections relating to

different influential factors such as age, gender, cultural identification and resource allocation. These affect the contact between addict and professional for the duration of therapy for substance dependence and associated issues.

Discourse regarding the harm minimisation model leads into a description of the changing concept of health. This is pivotal in the competition and co-operation currently being experienced by facilities in the field. The next chapter discusses and summarises the results of the interviews and compares the findings with literature reviewed in the second chapter and methodologies in the third.

Client Assessment and Treatment Matching

There is a crucial stage for every addict, which influences the entire sequence of potential improvement from a drug dependent lifestyle. Each interview participant reiterated this point. Successful client assessment and treatment matching are vital in every addict's first contact with drug centres. Addicts are not part of a homogeneous group. Every person, according to G, presents with a multitude of complex issues and factors. H and C stated that people of minority cultures required diagnosis, screening and evaluation preferably by members of their own culture, or at least by gatekeepers who are culturally aware and sensitive. The need for increased cultural sensitivity and awareness is becoming more pronounced every day, according to H. B noted that there are only four primary assessment gatekeepers in Christchurch, and this implies members of certain minority groups cannot access sensitive services in their initial contact with health care facilities. G admitted that to the best of his knowledge, there are currently no facilities or therapists here—apart from Māori and Pacific Island counsellors and programmes—who identify as being members of, or culturally aware and sensitive to addicts from non-European continents.

The therapists and counsellors involved in assessment and treatment matching are not part of a homogeneous group. G stated that all professionals in the domain have their own theories and methods, which they use during their encounters with clients. The treatment and assessment addicts receive is the result of a dynamic relationship between themselves and the therapist: sometimes it is successful, while at other times it requires different professionals before a dynamic social interaction producing a positive,

reciprocal relationship is established. G pointed out that many people would not return for diagnosis and screening from another counsellor, at least in the immediate future, if their last contact was a negative experience. G also mentioned that perhaps there are those who never have the chance to come back because of death. Therefore, in many cases the first meeting between addict and health care representative is crucial and requires staff with a high level of competence and training. B noted that there are many factors that influence whether an addict feels comfortable enough to provide the information needed to establish a successful assessment and treatment.

The successful diagnosis and evaluation of an individual presenting with drug dependence issues, according to G, is the most important part of the entire process. It is critical that a professional screening result in the most effective service offered to the individual right from the original exchange of information. This is fraught with difficulty because many clients at initial presentation exhibit denial, discomfort, frustration and anger, and negative cognitive schemata, resulting in a high level of ambiguity for the gatekeeper, according to E. The chances of successful goal identification, achievement and maintenance are directly related to the first interaction between service provider and client. In order for this to occur, people need to feel safe in the therapeutic environment and believe they are speaking to a person they can relate to.

Assessment of addicts by professionals, because it requires specialised training, usually occurs in the initial contact. D argued that although many addiction professionals have received extensive training, they still tend to use favoured techniques and this reduces the eclectic potential of their diagnosis. He noted the abstinence versus controlled drug use debate as an example of this and mentioned that both fall into the harm reduction or minimisation model. B stated that there are four gatekeepers in Christchurch, which perform the bulk of the assessments. An assessment, according to F, involves identifying the person's problem(s) and their severity, why these problems exist, what can be done to change them, and how this is going to occur.

The potential chances of successful diagnosis and treatment matching, according to D, are increased through the use of multidisciplinary teams of professionals. In this way staff can monitor each other and maintain a high level of service. H argued that because all aspects of his centre are continually scrutinised by society, staff motivation to provide the best service they could is increased because they are constantly being evaluated. G

mentioned, however, that there is a huge need for more professionally trained addiction therapists and this is especially true for members of minorities, who are presenting in increasing numbers.

Treatment matching is interrelated with assessment. Treatment centres and programmes are discussed with the client and, through positive matching, the chances of improving the quality of life for the addict are enhanced. The inclusion of the client in the service matching process is crucial for successful outcomes, according to G. Simply stating where the client should present for treatment decreases the likelihood of maladaptive behaviour modification. All the interviewees agreed that any steps, which resulted in harm reduction for the client, are perceived to be in the right direction. A critical element of assessment, noted by all of the informants, is the risk of potential harm to the clients and the public. It is of vital importance that people with substance dependence issues reduce the most potentially dangerous aspects of their behaviour as quickly as possible.

G argued that when clients are presented with options for treatment, their motivation to change their addictive behaviour is improved. In the socioenvironmental model clients play a more constructive role in their own treatment, according to H. That is, gone are the days when addicts were expected to undergo treatment in programmes of the clinician's choice and it was assumed that they would consent and endure the dictates of the centre. If they did not, then they obviously did not want to be helped or cured. "The clinician knows best" attitude was perpetuated by the biopsychological model which emphasised that experts stipulate the journey of recovery and addicts should not question or resist treatment. The limited options of mainstream health care services is one reason many people of minority cultures do not find suitable help in changing their addictive behaviour, according to H and C.

H and C also noted that many Māori and Pacific Island people in the past discontinued treatment due to defective screening, misguided diagnosis and botched evaluations by mainstream professionals. Experiencing such a poor service does not promote or encourage addicts to continue treatment, and many people have suffered and more will suffer because of a lack of cultural awareness of mainstream health providers. The scarcity of cultural sensitivity and holistic treatment, noted H, provided the impetus for establishing Te Rio Arahi. C in Pacific Island Evaluation Inc. reiterated these issues and

indicated that the formation of the Māori drug centre paved the way for the Pacific Island facility. The presentation of addicts from minority cultures has increased, according to G, resulting in the need for more specialised training and staff.

F stated that because the clients had all been assessed prior to arrival and matched to Nova, this meant that the staff could focus on treatment and the clients knew they did not need to provide more information regarding initial assessment. The age restriction at the Lodge promoted a particular milieu, which resulted in more treatment potential for clients, according to F. In essence, staff at Nova can concentrate on the treatment of adult alcoholics and users of mild addictive illicit or licit substances because the entry criteria excludes "junkies, pill poppers," and adolescents. Young addicts require the identification of treatment issues and factors that are different to older addicts, according to D.

Young addicts are susceptible to many influential pressures that need to be considered during the initial contact and diagnosis. D noted that this meant more specialised training for the staff at 198 and also that the centre required a high level of internal and external evaluation. The assessment of therapists performing the initial diagnosis should be thorough and meet some form of national criteria, according to G, which requires more research and funding. All the informants reiterated the call for more funding and increased access to resources. The different ages of addicts plays a pivotal role in their interaction with health care providers.

Age Differences in Assessment, Treatment and Outcomes

Many of the participants, except D and F, stated that each respective facility could treat clients of any age. D mentioned that 198 Youth Health only treated adolescents or young adults, while F at the Nova Lodge cared for those people older than thirty years. The rest of the sample treated clients of any age but C, at Pacific Island Evaluation Inc., cared for Pacific Island people only, and H provided treatment for all ages but focused on Māori policies and methodologies. G noted that CADS performed initial diagnosis of young addicts but referred them to relevant centres such as the youth programme at Odyssey House and 198. Māori or Pacific Island adolescents or young adults are treated at the respective centres by members of their own cultures, which would not happen if they

attended other facilities, according to H and C. This would lessen their chances of resolving or diminishing their addictive behaviour and thereby reducing harmful activities.

Contained in the sample are treatment centres catering to every age bracket of the general population of addicts. Two agencies, represented by D and F, specifically treat people of certain age groups. F mentioned that the four primary assessment gatekeepers assess the clients during the initial contact, but that the Lodge received addicts specifically placed there, which meant less stress on the facility during the induction process. All the people who presented at Nova had already been assessed and matched to the programme, and, therefore, knew that they were being sent to the Lodge because they fitted the entry criteria. G agreed with this and continued by suggesting it was good to place adults who have developed a dependency on alcohol and mild psychotropic drugs in the same institution. Referring addicts to centres that specialised in treatment means that programmes can concentrate their resources and consequently require less funding and can improve health care. The treatment of addicts in groups, according to G, is successful for many and results in financial gains for society.

Caring for the adolescent or young adult addict poses different problems to treating older clients. D noted during the phone conversation that many people experience difficulties when testing boundaries and exploring new aspects of themselves and their surroundings. This discovery of new facets of life and responsibilities, and consequent rebellion, is inherent in the growing process in the formative years. Problems treating individuals with addiction issues during this stage in their development are compounded by their tendencies to exhibit unusual or extreme behaviours and strive for new experiences in the determinative teenage years.

There are other different aspects to treating the young which become pronounced in comparison to the mature addict. Many addicts, in the later stages of their lives, suffer from maladies which may not be the result of their dependence on substances, but effect the individual's life to some extent, according to F. After many years of drug dependence, older addicts usually exhibit more pronounced symptoms and behaviours which their bodies are not as capable of sustaining for as long as when they were young. In addition, older addicts usually have many more experiences to come to terms with as

a direct result of their drug using years. Older addicts have more established patterns and cycles, according to F, which require longer treatment.

F stated that because of the ages involved at the centre, and the sort of clients they treated there, which she said were some of the worst because no-one else would take them, meant any slight reduction in harm was a step in the right direction. It is due to the relapse potential of the clients, and the safe milieu at the facility that resulted in it being known as the "revolving door" centre. Interestingly, E, F and G all stated that their respective programmes treated people that other centres would not admit. The Mission, according to E, accepted the addicts on the streets and therefore treated those with nowhere else to turn to. F argued that Nova provided therapy for those who required long term care and could not find help elsewhere, which again, like The Mission, fills a specific niche in society. G noted that the only HFA-funded psychiatrist was located at CADS and resulted in the centre caring for those others could not treat. All the programmes, then, offer their services to particular groups of addicts who present with additional difficulties in comparison to mainstream addicts. The implications and consequences of this are explored in the next chapter.

H and C mentioned that there are additional pressures placed on individuals who identify as being members of a minority in society. These pressures need to be addressed and treated, which requires a different style of service to that offered by mainstream facilities. These differences affect the establishment and maintenance of goals or outcomes of treatment and in many ways these clients cannot be compared to the general population. Specialisation of services, according to H and C, will lead to improved treatments for more people of all ages suffering from substance dependence.

H argued that because the Māori place greater value on their elderly and the whānau, this changes the way minority addicts receive treatment, their goals and outcomes. The additional dimensions to the treatment of minority individuals who seek help to live without chronic addictive behaviour, and yet experience negative discriminatory societal pressures, potentially increases the time they take to come to terms with their dependence on substances and their negative coping strategies.

D stated that there are influential forces on adolescents and young adults that need to be considered when treating them for addiction. These include the presence of anti-

social parental behaviour, inadequate knowledge about drugs and their effects upon the body, and a greater amount of peer pressure because of the formative years and lack of experience. Some of the clients treated at 198 are still at or have just left school and this requires liasing with members of the education system. Many of the addicts, because of their age, according to D, have had contact with governmental agencies and this too has required liasing with bureaucratic representatives. These issues compound the amount of energy and time required to help young people with dependence issues.

In addition, clients presenting at 198 may have issues with parents, older siblings, friends of the family and the law, according to D, that need to be identified and acknowledged by the health providers. Young addicts may show maladaptive behaviours in personal, social, psychological and emotional areas which, when combined, present difficult assessments requiring complex treatment. The utilisation of the Drug Use Screening Inventory (DUSI) provides a guideline for staff at the centre, whose primary objective is promoting harm minimisation. Some of the employees at the facility advocate abstinence from substances and others advise controlled use, according to D. All the staff, however, endorse harm reduction as a primary immediate goal. Ironically, whether or not a young person is advised to continue their drug use in a controlled manner or to cease and abstain is related to which therapist they are allocated, and this is an unusual situation, noted D.

All the centres researched provide clients with one or more of the different forms of treatment. These, discussed in Chapter 2, are Primary, Secondary and Tertiary. According to H and C, the principal treatment of addicts who identify as members of minorities is not comprehensive or holistic enough in mainstream services. The respective centres of H and C, do offer Primary treatment options, because these are not the main methodological focus. That is, minority agencies do not provide Primary care because it does not fit into the holistic care they offer. In short, C and H work in facilities that do not offer brief treatment.

B, C, E and F work in centres offering Secondary and Tertiary care with residential capabilities. H, D and G work in programmes also providing Secondary and Tertiary care but there are no medium- or long-term residential facilities. Many of the centres offer Primary care to some extent, but G stated that Nova was geared towards lengthier stays. B, E and G work at facilities operating with time frames for addicts in which

treatment occurs. This is the case for Odyssey House and QMH. Graduation usually occurs on successful completion of both programmes, which can take up to two years at Odyssey House and is currently approximately five weeks at QMH. All the centres catered for addicts of both genders but some had residential facilities, like The Mission and The Bridge, while others only offered temporary short-term stays, like Te Rito Arahi. Many of the sources had noticed that the gap between the genders that present for treatment is shrinking.

Gender Differences in Assessment, Treatment and Outcomes

All the centres provide treatment for women, although, again, age and cultural identity (see the next section) will determine where they receive treatment. H, C, D and G stated that the centres where they work do not have any separate facilities for women but do provide segregated programmes and counselling for female clients. B, E and F noted that they have separate wings or residences for women, while F also mentioned that some of the women do not want to have separate programmes from the men. All the centres employ female staff for those clients who choose to be treated by a member of the same gender.

Throughout the interviews it was apparent that men are the majority in all the treatment facilities and consequently many of the programmes are designed by men for men. Women require specific treatment because they are under different pressures. Many women have children who must be taken into consideration when establishing goals and outcomes. G noted that many women present with issues such as sexual or violent abuse and that on the whole their drug usage is not as long as that of the men.

G expressed concern about the treatment of women in Christchurch and noted that there are not enough facilities to deal effectively with the current situation. He suggested that a great deal more research needs to be conducted into women and minority addicts because in both cases there is an apparent population increase and the current health providers are not meeting their specific needs. These points were reiterated by H, B, C and E.

E stated that many women did not feel safe divulging their personal experiences about sexual or physical abuse in the presence of men and at times this reduced their chances of successful treatment because these issues required resolving. Therefore, health care providers are required to offer separate spaces for women where they can receive help and not feel threatened in the presence of men. H mentioned that these difficulties experienced by women are increased if they do not receive culturally sensitive treatment.

One of the most important facts about women and sexual abuse, according to G, is that it is under-reported and requires more specific screening which, in turn, necessitates specialised staff with higher levels of training. It is well known that sexual abuse, whether perpetrated during childhood or in later years, increases the risk of relapse for women, especially those who do not divulge its presence during treatment. Both E and G stressed that there need to be comprehensive investigations into sexual abuse, addiction and health care. In addition, G noted that sexual abuse is common in women presenting for help with substance dependence issues.

An unknown percentage of addicts seeking treatment belong to or are affiliated with the homosexual community. Every participant was asked about his or her facility's capacity to treat members of the gay community and each replied that there were special counsellors trained to provide care for gay or lesbian clients. Collectively, they also stated that none of the centres had specialist facilities for treating members of this subgroup. Perhaps this is related to either the number of gay or lesbian clients who are forthcoming about their sexual orientation, or the way the general population views gay and lesbian people. There could be a multitude of reasons for this, but without more data any hypothesis would be speculation.

E mentioned that many people who identify as homosexual would not disclose this at a predominantly heterosexual treatment facility. B, D, E, F and G stated that gay or lesbian clients produce difficulties for the respective centres. If a client with drug dependence issues presents at a centre with more than one minority affiliation this poses additional problems in their assessment and potential treatment.

Cultural Identity or Affiliation

H, at Te Rito Arahi, clearly noted from the beginning of the interview that the centre existed to treat Māori people because they were not being treated effectively by mainstream health care providers. Although anyone could receive treatment at the facility, it provided programmes using Māori ideologies and methodologies. Its primary focus is to help people who identify as members of the Māori culture in appropriate ways. He also mentioned that anyone could receive treatment at the centre but would be treated with Māori protocol and receive counselling and therapy with policies and methodologies based on a Māori interpretation of the current situation—that is, a holistic emphasis on the interrelated influences from all aspects of life on the addicts.

Both H and C work in centres that have only recently been established. Te Rito Arahi began in 1985 and has had to fight for funding and resources ever since. H stated that the facility is under constant surveillance, which he thought was good because it kept everyone at an optimum level of professionalism. The lack of resources, however, has meant that staff are required to spend some of their time attempting to obtain more funding instead of treating addicts, according to H. With time the government will have to increase the amount of financial support because the number of people presenting for help is increasing. C at Pacific Island Evaluation Inc., which began in 1990, mentioned that it was similar to the Māori centre in its staff activities and lack of resources. Ideally, both centres would be able to offer comprehensive services for more people if they had adequate resources.

H continued that many Māori people require holistic treatment with a focus on the whole individual. The way Māori people relate to and are treated by mainstream society influences their drug taking behaviour and consequently, noted H, requires incorporation into treatment. The drug use of a Māori person, according to H, usually affects and involves the whānau, the iwi and mainstream society. All these factors need to be taken into consideration along with an individual's past and their relationships with ancestors and the spirit world, which are also extremely important.

Conversely, C stated that his centre specifically provided treatment only for those people identifying with the Pacific Island culture. This encompasses people from many of the islands north of Aotearoa, (see the third interview in Chapter 4). The assessment

and treatment Pacific Island Evaluation Inc. offers is exclusively dedicated to understanding and helping Pacific Island people. The rest of the sample participants, excluding H, worked at centres providing predominantly European-style treatment and advocating Pākehā policies and methodologies that are, in many cases, not appropriate for people who identify as being members of other cultures. B, D, E, F and G, however, noted that their respective programmes offered culturally sensitive treatment. H and C argued that people presented at their centres because they had received deficient services elsewhere.

C, like H, mentioned that the way minority people relate to and are treated by mainstream society influences their drug use. The family is important for Island people and drug abuse by one person affects the entire extended family. There are pressures on Pacific Island people that are not experienced by Palangi, and this must be taken into consideration during their treatment. A Palangi would not know what it is like for someone from the Islands and, even though they may have the best intentions, they might not be able to help the Pacific Island addict because of cultural differences.

H and C noted that there seems to be an increase in the number of people presenting for treatment and that both centres need more staff and resources. B mentioned, during the interview, that The Bridge Programme was currently attempting to find ways of becoming more culturally aware and offering increasingly culturally sensitive services to members of minority cultures. Due to the additional pressures of living in a European dominated society, addicts from minority cultures usually present in higher numbers and with increased rates of co-morbidity.

Specific Needs and Multiple Diagnosis

People presenting with co-morbidity, which, according to F, has increased in comparison to the past, need more intensive assessment, screening and treatment matching to increase the likelihood of successful goal identification and attainment of positive outcomes. Many centres in the sample do not employ professional staff with the necessary skills or training to assess or match clients with dual or multiple psychological or physiological maladies. CADS is the only facility to employ full time a psychiatrist and psychologists.

All the other participants, apart from F, mentioned that if a person presented with dual or multiple maladies, they were usually sent to CADS for confirmation of diagnosis. Of the four main gatekeepers, according to B, CADS is the largest and has the most staff and programmes for treating clients with multiple addiction-related ailments. This presents problems for people identifying as members of minority cultures because they would not receive culturally sensitive treatment from CADS, according to H and C. Addicts suffering from severe multiple diagnostic maladies cannot be treated in the culturally sensitive surroundings provided by the two minority orientated facilities because there are no highly qualified staff. Every informant agreed that the rate of presentation of multiple malady clients was increasing. However, G stated that CADS was capable of treating minority addicts in a culturally sensitive manner.

E mentioned that The City Mission treats or provides services for many people at the very bottom of the addict population. The agency maintains a night-shelter and other facilities for people who do not reside at a permanent address. This influences the overall results of those clients perceived to be able to maintain their goals or desired outcomes, and, consequently, affects the amount of funding available for the facility and other centres. Addicts suffering from dual or multiple maladies, although treated by CADS, would still require a place to spend the evening and by associating with others on the streets are more likely to relapse or regress in their attempts to live a life focusing on harm minimisation, according to E.

G disagreed with F about the increasing frequency of the presentation of people with co-morbidity. He argued that co-morbidity has always been present at these levels, but that as the scientific community provides more comprehensive knowledge, and consequently the medical community can access more information, this has changed the diagnosis of addicts. In the past, addicts with co-morbidity could expect to receive fewer treatment options and resources because they were perceived to have less chance of successfully maintaining behaviour modification, according to G. Currently, however, the medical profession is able to offer more treatment options and an increased likelihood of a successful outcome.

All the interview participants, apart from F and G, stated that cases of multi-diagnosis were sent to CADS because that was the only facility with the professional staff capable of assessing and treating co-morbidity. This presents a paradox, which will be explored

in the next chapter. One of the reasons for this lack of ability to assess and treat clients presenting with co-morbidity is directly related, according to all the informants, to a lack of funding and available resources.

Resources and Funding

All the participants stated that the bulk of each respective programme's finance comes from the Health Funding Authority (HFA). They also unanimously agreed that the HFA does not provide enough funding to support the scope or range of services required. All the agencies could offer more treatment options and resources if they had increased access to resources. Currently there is a waiting list to receive treatment at some of the centres. B noted that the time required for an individual to receive help at QMH, for example, is approximately three to four months. Addicts are dying while they are made to wait for treatment because there is simply not enough available space due to lack of money.

The deficiency in funding is more extreme for agencies providing specialist treatment, such as those assisting cultural minorities or specific age groups, according to H, C, D and F. Again, because of the particular method of HFA funding approval—counting the people passing through the facilities—those centres with specific target clients will continue to receive less funding in the future. In addition, centres which provide holistic treatment cannot care for clients as quickly as specific European facilities, and are therefore in urgent need of increased resource allocation, as noted by both H and C.

The lack of funding also limits the extent of potential health care and many centres cannot effectively diagnose or screen addicts because they are not able to employ highly qualified staff. This does not effect Nova because they do not need to assess or match clients, according to F, but the other care providers, apart from CADS, all require more resource allocation to employ staff capable of diagnosing and screening co-morbidity or multiple malady addicts. G noted that with the current bureaucratic procedures and intensive criteria, the chances of obtaining more funding in the near future are relatively slim.

Lack of resources and funding, and an increase in the emphasis by the present government on domestic care, has resulted in clients with dual or multiple diagnoses suffering intensified hardship, according to G. The need for more funding and resources for culturally sensitive treatment of minority addicts, and indeed all addicts, is exacerbating the imbalance between prospective clients and services offered. G mentioned that an increase in funding was required in every area of addiction. This includes training social scientists to carry out needed research to support qualified professionals and health care facilities. All the informants agreed that this society urgently needs to improve its understanding of addiction and treatment. For example, whether an addict is advised to continue taking psychotropic substances in a controlled manner or to abstain is related to which therapist she or he goes to see for help, irrespective of whether the client is capable of either.

Harm Minimisation and Abstinence

For the informants the initial interaction during the assessment between client and health professional focuses on immediate practical safety needs of the client and the public. That is, the first assessment, screening and diagnosis of a drug dependent person, as noted by H, B, C, D, E and G, should assess the severity of the problems, the underlying motivations for the continued behaviour, and identify strategies to deal with the associated problems. G stated that although a great deal of importance is placed on the proper assessment and correct treatment matching of a client to a regime, it must be conducted when the gatekeeper registers a lowering of the addict's distress levels. That is, if an initial assessment takes place when the person is extremely distressed, then it becomes limiting and could produce the opposite to the intended outcome.

Harm reduction, then, is the primary goal of all the centres. All the interviewees mentioned that each step resulting in the potential harm reduction experienced by the client is in the right direction. However, there is a discrepancy between the treatment providers' understanding of what steps in the right direction are. H, C, E and G, all work in centres which care for "using" clients. Indeed, G mentioned that many of the professionals at CADS prefer to treat addicts still using substances because this established a baseline from which to monitor any changes in client behaviour.

Conversely, B and F stated that The Bridge and Nova only accept people into the programmes who are already abstinent. The Bridge does have a detoxification unit but if an addict uses a substance during treatment they are no longer allowed to continue the programme and are asked either to detox again or leave until they are ready to return. This is also the case for Odyssey House and QMH where, if clients are found using a substance, they are immediately forced to leave the programme. Abstinence is not a requirement for membership of twelve-step programmes, such as AA and NA. The only criterion is the desire to stop using; members are encouraged to stay drug-free by relating experiences and group support.

D mentioned that when a client received counselling, whether the emphasis is placed on abstinence or controlled use is up to the individual professional at 198. It would appear that some of the professionals treating addiction advocate abstinence, while others prefer to care for those still using substances, and in some cases both may practice at one centre. Again, this is another paradox which is discussed in the next chapter.

B noted that current changes being discussed might result in clients at The Bridge being accepted from the methadone programme. This would mean treating addicts still using substances and changing the emphasis of the treatment programme. Harm minimisation is vital in the treatment of addicts as the use of any drugs may result in immediate harm or in some cases even death. Overdosing is a common experience for many intravenous users, according to G. Viral infections such as hepatitis are also common amongst this group of addicts, as is liver damage in alcoholics, noted F. Any changes which result in the reduction of potential harm for the clients is an improvement.

This ideology might mean the promotion of certain behaviours, even if they are known to be hazardous, provided other, more dangerous behaviours are limited or reduced, noted G. Many addicts smoke cigarettes and some counsellors and therapists advise their clients to continue smoking, at least for a while, because trying to stop at the same time as reducing the use of more dangerous substances does not fit into the harm reduction model, as argued by G. Similarly, E contends that if an alcoholic prefers to drink and drive it is the driving which needs to be stopped in order to reduce the potential of immediate danger in the life of the client and the public.

The harm reduction model does suggest any behaviour that lowers the potential danger to either addicts or the public is acceptable. The model advocates either abstinence or controlled use of substances, which presents the clinicians with more options to offer their clients. G stated, however, that problems occur because therapists advise some addicts to attempt abstinence when they are not capable of it, resulting in harm, while they advise others to control their drug intake when they are simply not able to, also resulting in harm. Training counsellors to distinguish between the addicts who require either treatment for enhanced outcomes is one of the most important contemporary qualifications, according to G. Referring clients to centres, which exclusively advocate either is a skill essential for contemporary gatekeepers.

Harm minimisation is a recent change in the strategy of addict treatment and indicates to some extent the amount of flexibility inherent in the addiction domain. All the participants indicated that successful treatment of addicts must consider a range of environmental influences. These include the society addicts live in, the changing focus of health providers, and regimes adhering to policies and ideologies which are not static but open to modification and continual improvement. Included in this adaptable philosophy is awareness of the changing concept of health.

The Concept of Health

All the informants were asked about the biopsychosocial model in comparison to the newer socioenvironmental model and their respective applications by the centres. All the interviewees agreed that there has been a shift in the emphasis of treatment for drug addiction. The shift towards a more holistic approach was confirmed and approved by the participants, who mentioned that the older model was still adhered to by some treatment providers, but that there has been an increase in the available knowledge for professionals involved in treating addicts and consequential improvements in programmes.

For H, the shift towards the socioenvironmental model presents a coming together of Māori and mainstream health providers due to the inherent holistic nature of the Māori ideology. Māori counsellors and therapists employed at drug treatment centres already focus on spiritual, cultural, social, physiological and psychological influential forces

present in the environments of all their clients. The primary objective for Māori professionals is promotion of harm reduction, according to H, and this occurs because they emphasise the balance of these separate but interrelated dimensions.

In the past addicts were expected to follow the suggestions of experts who knew what was best for them, according to E. Sometimes this resulted in deficient services because the needs of clients were not considered. The opening of the two cultural minority centres is a direct result of the inadequate concept of health advocated by addiction experts in the past. The increasing amount of co-morbidity or multiple diagnosis is another example of the changing scope of health, noted G. In today's health care facilities, the requirements of the clients are the primary concern, and harm reduction is the predominant philosophy.

The harm minimisation principle is the central ideology in providing synthetic heroin to addicts, thereby replacing their need to commit crime or hazardous activities to obtain money for drugs. G argues that recent studies indicate that people who are given Methadone commit fewer crimes and consume less illicit drugs, thereby reducing the amount of potential harm, lowering the burden on social institutions and decreasing the negative consequences of criminal activity. In contrast, clients need to present at QMH abstinent from all drugs, although the resident doctor can prescribe medication to alleviate withdrawal symptoms.

Abstinence is also a requirement for Odyssey House, which conducts regular urine testing to confirm clients' co-operation. G noted that the abstinence requirement is a barrier for some addicts, who require help to reduce their intake of drugs before they can attend a residential programme such as QMH or Odyssey House. The abstinence versus the controlled use of drugs in the harm minimisation principle is a paradox discussed in the next chapter. The associations and interdependence of some centres vying for a limited resource is outlined in the following section.

Competition and Co-operation

E stated that The City Mission was in competition with other agencies such as CADS for funding from the HFA. According to E, this promoted co-operation between the

agencies, involving closer reciprocal sharing of information and an increase in the level of services provided to addicts and wider society. G, however, disagreed with E and stated that the limited amount of available funding necessitates a competitive environment and reduces the level of co-operation between agencies, using vital time for facility staff to pursue resource avenues for more funding.

This competition between facilities for clients does not apply to such an extent for H, C, D or F, because they provide treatment for specific subgroups in the addict community. The limited resource allocation, however, does inherently interrelate all the centres because the amount of available funding is capped for a particular time frame and given to the programmes on the basis of client numbers. H, C, D and F, work at facilities catering to specific addict minority members which reduces their potential client base and lowers consequential funding. This too, is another paradox that is discussed in the following chapter. The establishment of culturally aware aspects and culturally sensitive trained staff at The Bridge will present a choice to clients of minorities, but may result in less funding for centres such as Te Rito Arahi or Pacific Island Evaluation Inc.

Centres that maintain the abstinence entry criteria compete with other similar facilities only, but, given the increasing usage of the harm minimisation model and growing cultural awareness, if they begin treating minority addicts still using substances, then they would compete with all the other programmes for clients. G noted that, due to the limited HFA funding, the crisis currently experienced by many addicts seeking help is likely to continue and increase in severity if health providers have a similar or lower level of access to resources in the future. Competition for a limited resource by centres offering the same services can only result in less co-operation and information sharing between the facilities, which will lessen the potential treatment options for prospective clients.

The increasing numbers of clients using new drugs, searching for synergy, according to G, requires more co-operation between centres and this will not occur without more funding. Indeed, all the informants stated that there are more people who exhibit complex substance-dependent maladaptive behaviours needing help. This requires an increased level of resource allocation by the funding providers.

Summary

The process of assessment and client treatment matching is crucial in establishing the groundwork for the addict's consequential goal and outcome attainment. Addicts, however, do not belong to a homogeneous group, but reflect society. Neither are drug treatment therapists and counsellors, part of a homogeneous group. They adhere to different policies and use various methodologies. Thus, the initial contact is fraught with difficulties, which may result in addicts withdrawing from health care providers for many reasons.

The initial assessment should convey from addict to health professionals certain information which, if it is not conveyed, will decrease the chances of successful treatment. Treatment matching of clients to centres is critical and interrelated with constructive assessment, but, again, if there is not enough information it will be less successful.

The more available options for addicts, the better the potential for successful treatment. This is especially true for individuals who identify as members of minority cultures or groups in this European dominated capitalistic society. To meet the demand of Māori and Pacific Island people, two centres have recently been established in Christchurch, which can only help to improve successful outcomes, by providing specific treatment policies and methodologies. If treatment becomes more specialised, services will improve because it will be possible to concentrate resources. Future centres will be required to meet the diverse needs of addicts, again reflecting the changing demographic composition of Aotearoa.

The need for specialisation of centres and concentration of resources was indicated by centres treating specific age groups, which present the respective facilities with a plethora of age-associated issues. Younger addicts, for example, require different treatment from that of their older counterparts, each group reflecting different stages and different pressures in life. These differences are, of course, intensified if the younger or older addict identifies as a minority member and they increase exponentially if the addict is female. Women have different requirements to men and yet many of the treatment centres in Christchurch do not provide specialist care for them. Several centres do offer programmes for female addicts, and others have separate residential facilities, but it is

apparent that more research and emphasis needs to be concentrated in this area. This gap in the treatment services for women is more pronounced for members of the homosexual community. Lesbians or gay men are able to receive only limited treatment and are not able to attend a specialised centre in Canterbury. The next chapter discusses and compares the implications of the findings presented here with other research.

By their existence the Māori and Pacific Island centres improve this region's ability to offer culturally sensitive services, but more research needs to be conducted in the area of specialised treatment. Specialisation in multiple diagnosis is becoming increasingly essential because the numbers of addicts presenting with co-morbidity are escalating. Whether this is because there are now more categories professionals can place addicts in, or there are simply more addicts presenting due to different post-modern societal pressures, does not change the rising numbers. Again, more research is urgently required in this area.

The lack of funding and available resources affects the amount of potential research and consequently limits the range of specialisation offered by treatment centres. Research into the extent of adherence to the harm minimisation model is critical because some centres offer their services to abstinent addicts only. In addition, as part of the harm reduction philosophy, counsellors and therapists may advocate continued or controlled use of substances for particular addicts if and only if other potentially more harmful behaviours, to either the addicts themselves or the public, reduce or stop. In the interim, however, addicts are dying because they are being made to wait for places in treatment centres due to either the lack of funding or abstinent entry criteria, or both.

Ultimately the harm minimisation model demands that professionals become flexible in polices and methodologies when treating addicts. It seems some still advocate the biopsychosocial model, in spite of the fact that recent research has shown the holistic socioenvironmental model to be more practical for successful treatment of addicts. Melding the two main models together and advocating the formation of a baseline, thereby closely monitoring behavioural changes, offers increased potential for successful addiction modification. Professionals would then be required to avail themselves of the latest information and be aware of the flexibility of the concept of health in Aotearoa and abroad.

Increased resource allocation is vital to extend the options available to addicts, and it can only lead to beneficial policies and methods of treating addiction. Any situation which promotes research, education through information sharing, and the co-operative interdependence of addiction treatment centres, must result in improvements for addicts and the general public.

Chapter 6

Discussion

Introduction

Contemporary society stands on the brink of a socio-economic disaster. Addiction is a growing societal issue that has been neglected in the past and is threatening to consume a greater share of health care services and resources. Ironically, with a significant increase in the amount of funding this imminent catastrophe could be averted. The number of people experiencing problems with substance dependence and related issues is mounting at a steady rate and saturating health care providers. Considering that only one in five addicts seeks help from recognised services, if the majority of people with substance dependence issues suddenly sought help from professionals current agencies would be inundated. This suggests that resource allocation to stemming and decreasing the steady accumulation of addict figures needs to be relatively vast. However, the immediate financial alleviation of this burden would lessen relatively quickly because, as suggested by researchers (Galanter, 1999), addicts may help in the treatment of others, thereby substantially reducing the expenditure required for service maintenance.

This, the last chapter, is split into two main sections after the initial segment detailing methodological topics. This thesis has highlighted several central issues that require urgent rectification. Before these issues are considered, however, several points which require clarification arose during the collection of data. Giving knowledgeable consent is explored in detail and the validity and reliability of the methodology are revisited. Then, the central themes are identified and discussed.

The last section details the paradoxes of addiction, which need and must be resolved before there can be any forward progression. These paradoxes were listed in the introduction and are vitally important to all aspects of addiction treatment. Each has its own discussion and these are followed by the conclusion.

Methodological Issues

Preconceptions do indeed form our perceptions (Seidman, 1994): this research design was informed by some such preconceptions. Issues that have emerged in the course of the research make it apparent that, if the research were to be repeated, some aspects of its design would have to be different. The degree of flexibility in the methodological design was not malleable enough to provide adequate guidelines for the questioner. Events during the information-gathering process highlighted my lack of foresight. Attempting to confirm the knowledgeable consent of non-English speaking people and the affirmation of a participant who had his consent form signed on his behalf proved to be extremely problematic.

Giving Knowledgeable Consent

While obtaining the data I was presented with several ethical choices and moral dilemmas. The phone interview, due to lack of physical cues, could have been undertaken with anyone at the centre who answered the telephone. Out of necessity, I had to trust the participant and believe that the person on the other end of the line was a staff member at the centre. The ethical issues arose when the participant asked to conduct the interview over the phone. Trying to ascertain whether a person has understood and agreed to give consent over the phone is more difficult than in a face-to-face interview.

The guidelines presented by the Ethics Committee stipulated that an interview could not progress until the participant has read the documents, understood the available information and signed the consent form. In this case signing the consent form was not possible until later and ascertaining the level of understanding of the interviewee was entirely verbal. Taking into account the ethical implications of the situation and advising the participant of the moral guidelines contained in the documents resulted in the continuation of the interview.

The gatekeeper at The City Mission posed another ethical dilemma when she signed the consent form on behalf of the participant. Merely advising the interviewee that the consent form had already been signed and asking his permission to continue did not

change the fact that she was his superior and that E might have felt compelled to take part in the interview.

Assuming that E's superior had asked him rather than delegated him to take part did not alleviate the ethical implications of forced participation. E did take part in the interview but his rationale for doing so will never be known and the ambiguity of the situation resulted in a moral predicament. Being aware of the potential implications, and not knowing some of the antecedents, left me with no choice but to rely on E and continue the process. Getting E to sign another consent form could have averted all this, but this too would have been ethically questionable in relation to the gatekeeper. Apparently, gaining consent at times may be ethically questionable, but providing the researcher has followed the guidelines and ascertained that the informants are aware of their choices then there is nothing more that can be done to reduce the ambiguity.

Validity and Reliability Revisited

The reliability of the research is in question because of the method of data collection. There was information degradation during several of the transcriptions because of the time between the two events of recording and transcribing in one instance and language difficulties in another. In addition, two interviews were not recorded: I had to rely on scribbled notes for transcription. The research has a low reliability or repeatability potential. The problem with validity in this research is that it is limited to construct. There is simply not enough information to imply any criterion or content validity. The reduction of the interviews to seven out of the potential nine has further reduced the construct validity of the information.

Both reliability and validity have been affected by the sample selection, which was not random, and therefore cannot be a representative sample of the wider population. I chose the sample based on selection criteria of my preference and thereby lessened the generalisable potential of the gathered information. In essence, the data is only useful as a comparison between the seven centres and with the available literature. However, even here there are problems because the gaps in the data are obvious only at the correlation stage of the information. A pilot study, time permitting, would have been

invaluable for this thesis. The information obtained from the interviews does, however, offer some insights into the domain of addiction in Canterbury, Aotearoa.

Central Themes

The literature review, in Chapter 2 and the findings in Chapters 4 and 5, have shown reoccurring themes which are reiterated by many professionals, including the seven participants. The primary concerns of every professional are the limited amount of available governmental funding and lack of accessible resources. The paucity of relevant research information in all areas of addiction world wide is echoed in Christchurch. The scarcity of information is directly related to the gender, age and group size of addicts and may be correlated and compared with information about the general addict population. Addicts belonging to minority cultures are not researched enough and consequently receive less than adequate care. This absence of relevant information has resulted in reliance on treatment models that are not comprehensive enough for any addicts. A more holistic model that focuses on an addict's entire environment and behaviour, offers a better guideline for extensive and cohesive therapy. No forward progress, however, will occur without more money.

Funding and Resources

Future research and treatment are jeopardised by the lack of funding which would allow for more research to be conducted. Without an increase in funding, more addicts will continue to receive substandard treatment, risking exponentially increased potential harm to both themselves and their community.

More funding and resources are urgently required for female addicts, who have until recently been perceived as being incapable of having as severe or prolonged addiction problems as do male addicts. The gap between the genders is closing and the future suggests equality for women and men in this subgroup of society, with horrific implications. This decline of present standards will be even more pronounced for female minority members.

There is a particularly strong obligation for increased funding for programmes treating minority members in Aotearoa. The Māori and Pacific Island population can now access therapy, albeit limited due to lack of resources, for their addiction problems. This, however, does nothing for members of other cultures, such as the Asian and African communities, who are also not homogeneous and are growing in numbers and therefore increasingly require specialist services.

Future resource allocation must also be provided for the other categories of addicts, such as different generational groups and people with homosexual preferences. Addicts reflect the diversity of the wider population and consequently require specific health care.

More funding is the first step in the right direction. Without an increase in resources there can be at best only limited forward progress. This society needs to place addiction and its treatment higher on the hierarchical list of problematic social issues, and by doing so will be investing in this nation's future. Once begun, the process would begin to pay for itself when addicts help and care for each other.

Emphasis on Research

Secondary to the lack of available funding, but equally if not more important, is the meagreness of relevant literature. There is not enough data about any part of addiction—the clients, professionals and evaluation of centres; treatment models; minority groups; resource providers; public awareness—or even information about researchers themselves.

In short, there are no guidelines stipulated in a comprehensive model to assess the professionals or the addicts' responses to treatment. In addition, there is no comprehensive evaluation of centres, or data about the accessibility and usage of treatment by minority groups. Addiction professionals and researchers do not know how to educate the public or conduct inclusive research. These issues require urgent attention and funding to ensure that current levels of knowledge are elevated to match the growing problems.

The international literature discusses aspects of addiction, particularly pertaining to white, middle-class males, who comprise the majority of addicts in Western European countries, and only briefly mentions other facets of this multidimensional malady which has been present throughout the history of humanity. Indeed, the only conclusive hypothetical inference concerning all the other aspects of addiction is that there is not enough available information from which to make any conclusions.

Specific Treatments

The development of indicators such as minority treatment centres and more comprehensive models indicates there is room for improvement in the available options. The Māori and Pacific Island people can now find help at facilities offering culturally aware treatment and responsive environments. This increases the chances of successful behaviour modification for members who identify as belonging to either of these two groups. But what about the other minority groups in Aotearoa? Individuals from other cultures should also have the option of being able to attend a culturally sensitive programme in a safe environment.

This lack of specific treatment centres is also experienced by women, who do not have a specialised facility dedicated to the treatment of female addicts. Such a facility, by its very existence, will help to improve the chances some female addicts have of identifying, attaining and maintaining outcomes in treatment.

Women do have separate quarters in some of the current centres in Christchurch, such as The City Mission, The Bridge Programme and Nova Lodge, but a specific female treatment centre does not exist. Nor does a facility for members of the homosexual community. A gay or lesbian person cannot seek help with substance dependence issues from a professional with the same sexual preferences or in a specifically designed facility. Considering that people who identify as minority members probably experience discrimination in society and therefore have more complicated addiction issues, which in many cases require urgent treatment, the lack of such an agency is morally reprehensible. The minimal amount of funding available to mainstream programmes, however, suggests the establishment of a specific homosexual treatment

centre will not be possible in the near future. The absence of such a facility can only bode ill.

Enhanced Public/Addict Awareness

To increase the amount of pressure on politicians, who are in control of funding and resource allocation, the general public must be made aware of the current state of addiction treatment in Aotearoa. The public need to know that the situation is untenable and will result in increased suffering and hardship for addicts, their extended families, employers and social institutions such as health care and other welfare services.

By improving public understanding addiction and its consequences, people will recognise the benefit of funding research, training and increasing options for addicts. Glanter (1993) argues that establishing a system whereby addicts can help each other has proven to successful, with the potential of significant savings. Once the initial resource allocation has begun and addicts begin to avail themselves of needs-specific treatment, the process will begin to pay for itself resulting in improved outcomes.

There are many ways existing circumstances may be changed to alleviate some of the suffering experienced by addicts and the public. One of these is the clarification and remedying of the paradoxes that are discussed next.

Paradoxes

In the previous chapters certain issues have arisen that require elucidation by professionals so that the public can at least acknowledge their existence and understand what is at stake. Identifying the paradoxes begins the process of clarification and modification. The first paradox is the stereotypical separation of addicts by, predominantly, the older generation, professional addiction health care providers and addicts themselves.

Stereotypical Separation of Addicts

Why do many people continually separate alcoholics from other addicts? Initially the majority of people seeking help to overcome substance dependence issues were those suffering from alcoholism. This was a reflection of the societal norms and mores. Alcohol is legal and readily available, which promotes the its use and abuse. The type of clients presenting for treatment has, however, changed over time.

The increasing availability of other psychotropic substances and the number of people presenting with multiple substance dependence issues, has steadily increased and, consequently, resulted in the different attitudes and facilities currently available. However, Nova Lodge for example, does not treat addicts exhibiting dependence on intravenous drugs or substances known to have extremely addictive properties. The Lodge, then, exists to care for the older style of addict who primarily identifies as an alcoholic.

This separation of alcoholics from others addicts only leads to potential confusion. Instead, identification should be focused on how alcohol is licit, readily available and well established in society. Apart from the differences between legality, availability, and addictive qualities, which should receive attention during treatment, it must be remembered that all people who abuse substances are addicts and present with maladaptive behavioural issues which require modification. The continued separation of AA and NA is a consequence of this issue and promotes division between addicts.

All addicts, by definition, require behaviour modification and treatment should focus on influential substance dependence issues such as gender, minority affiliation, sexual orientation and age, rather than mere separation into alcoholics and addicts. In most cases treatment has resulted in better outcomes for all addicts irrespective of the substances to which they are addicted.

Treatment is Better Than None

Why are four out of five addicts not receiving recognised treatment? To present at a treatment centre and receive help to modify potentially self-destructive behaviour which leads to an increased chance of happiness would, it seems, be the only rational choice

for the majority of people. Yet only one in five addicts seeks treatment from recognised professionals in mainstream health care institutions. 80 percent of people in our society with psychotropic substance dependence issues turn to other regimes for help or attempt to treat themselves.

This strong trend indicates several important facts. First, that the mainstream professionals are not offering adequate services. Second, considering that treatment is better then none, the majority of the public including addicts does not know or is not aware of the potential health care on offer. Ironically, this scenario of avoiding recognised help is not new.

Addiction: Present Throughout History

Addiction is not a new phenomenon, so why is treatment of it in its infancy? Nearly every recorded culture has discovered an addictive mind-altering substance producing physical relief or pleasant experiences for the consumer (Neale, 1994). The paradox, then, is if addiction has been present in one form or another since recorded history, why is there so little literature about it? Since it has always been present why have those with the power to direct social resources towards alleviating addiction and its consequences, not considered it important enough for adequate attention?

Perhaps the current need for treatment is new because addicts have not presented in large numbers before. In the past, many people spent their time attempting to strengthen a tenuous grasp on life, and this would have been reflected in the numbers of addicts. Postmodernity has provided people with multiple pleasure seeking activities, and time to indulge. Advances in science resulting in the availability of numerous psychotropic substances, consequences of our "drug culture"—described in Chapter 2—have produced a wealth of options for individuals seeking relief from anxiety or distress.

Addicts have always existed, but pandemic polyaddiction may be a modern phenomenon. The presentation of polyaddicts searching for pleasurable synergy is the largest growing group of clients and they exhibit multiple diagnostic maladies. Current health care providers cannot adequately care for them, because they lack necessary funds for treatment and information about addiction. Perhaps successive governments

have not appreciated the cumulative consequences of inadequate funding for addiction professionals. The arrival of a new holistic treatment model, advocated by several minority groups, heralds a new age in health care.

Abstinence versus Controlled Drug Use and Harm Minimisation

How can diverse treatment centres exclusively offer either controlled drug use or total abstinence? Throughout the literature and echoed by all the interview participants is the professionals' support of either abstinence or controlled drug use. Ironically, proponents of each position argue that their policy promotes harm minimisation. Individuals promoting abstinence, such as the staff at The Bridge, The City Mission, Nova Lodge, Odyssey House and QMH, and some of the staff at 198 Youth Health, Te Rito Arahi, CADS and Pacific Island Evaluation Inc., treat addicts with a policy whose observance does decrease the potential harm a client suffers. There are, however, people who are not capable of abstinence without help and they suffer because they cannot attend a programme that stipulates abstinence in the entry criteria.

G mentioned that any harm reduction for the addict or the community was a step in the right direction and the Methadone Programme, which provides synthetic heroin, usually in gradually smaller doses, is a shining example of this policy. Perhaps one of the most important things this research has revealed is that whether a client is advised to stop using substances or to concentrate on reducing their most harmful behaviour depends on which professional that client interacts with. This debate will, in all probability, continue for some time to come. Perhaps both policies need to exist: their presence offers increased options for addicts.

Competition versus Co-operation

How can competition promote co-operation if competitors have identical requirements? E and G disagreed about whether competition leads to enhanced or reduced services for addicts. G mentioned that competition would reduce co-operation—an argument MacEwan (1999) supports. Myers explains why competition is inimical to co-operation: an "ecological principle, Gause's Law, states that maximum competition will exist

between species with identical needs" (1993; p.395). Considering that the treatment programmes have identical funding needs from the same resource provider, this would, according to the principle, minimise the potential for funding and co-operation. Consequently, this competition for clients would result in less co-operation.

The current situation, without a funding increase, is teetering on the precipice of disaster because several of the programmes, as mentioned by B at The Bridge, are currently attempting to increase their culturally sensitive services and thereby augment their competitive potential with centres who target minority groups. An escalation in resource allocation would improve the potential treatment options for addicts. Conversely, if the current level of funding plateau's or declines then the amount of competition will increase and potential services will decline because certain centres will not be able to continue offering treatment. This is compounded by the difficulty associated with treating multiple diagnostic clients who require more resources and health care options.

Increased Occurrence of Multiple Diagnosis and Assessment Difficulties

Why is there a significant increase in clients presenting with co-morbidity or multiple diagnostic maladies? This was noted by B, D, F and G, and reiterated throughout the literature, both national and international. People with multiple psychological or physiological maladies or both, require professional assessment, screening and treatment matching, which, in Christchurch at present, only CADS is capable of offering. The more severe the diagnosis, the greater the likelihood of clients being sent to CADS for confirmation and treatment. The increasing number of multiple malady presentations will require more professional staff with extensive training and experience to improve the chances of successful outcomes.

The growing numbers of polyaddicts indicate changing societal trends. More people are choosing to consume, and consequently become addicted to, a variety of psychotropic substances. New drugs are continually being discovered and their availability is becoming more accessible. People have more time to indulge and many are choosing to use drugs as a means of relaxing and reducing distress.

The need, therefore, for more funding for training professional psychologists, psychiatrists, therapists and counsellors is becoming more pressing. This trend could be occurring for numerous reasons, such as increased diagnostic categorisation or the effects of more readily available drugs, which, if combined, might produce disastrous synergetic reactions. Without a boost in funding and consequential research, services will increasingly deteriorate with exponentially multiplying negative consequences for society.

In Conclusion

Obtaining the data highlighted issues that differed from those I anticipated. The inherent flexibility of the research design was not enough to cope with reality. Confirmation beyond reasonable doubt, of knowledgeable consent is problematic at best, but impossible in many interview relationships. The interviewing process indicated many ethical and psychological issues.

The reduction of validity and reliability as a consequence of the information-gathering techniques has taught me an important lesson about hypothetical formulation and research design. The data from this thesis may be tentatively compared with the available literature but it would stretch credibility to claim any valid or reliable generalisable results.

One of the consequences of this thesis, however, is the identification of reoccurring themes throughout the domain of addiction, many of which were reiterated by the informants. There is a lack of funding and available resource allocation to professionals and treatment centres in Aotearoa. This failure to provide adequately for members of the population is exponentially increased if addicts are minority group members or suffer from multiple diagnostic maladies or both. Negative social consequences, such as crime and health maladies will be exacerbated if certain aspects of addiction are not urgently identified and treated.

Several other aspects of addiction also require attention: differences such as the growing similarities in addiction patterns between the genders and why this is occurring; the growing number of addicts presenting for treatment from other minority cultures; the

variance between addicts of differing age groups. The disparity between amounts of available relevant information is directly related to the number of addicts belonging to or affiliated with particular minority groups. The smaller the group the less the available information, which indicates hierarchical societal resource funding. Primary resource providers have not considered members of minorities with substance dependence issues important enough to fund research or establish specific treatment centres. Further research must be conducted to establish why there is a reduction between genders and why there are different trends in addicts of various cohorts.

Treatment centres for minority members are urgently required and the need for them is increasing daily. There is, however, a self-perpetuating cyclic pattern that must be broken before progress can take place. Increased funding will only be allocated as a result of research showing it is necessary, but for research to be done funding is needed. Educating the public, political and potential benefactors about addiction will grow only from more research. By breaking the cycle and increasing the amount of available data through funding more research, society should be able to alleviate or negate several of the paradoxical situations in the treatment of addiction. Every person, addict or not, has the right to expect specific help from qualified professionals if they require it.

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Appendix A

Introductory Letter

A Comparison of the Policies and Methodologies
Adhered to by Drug Treatment Centres
in Christchurch, Aotearoa.

Richard Van Kuppevelt Dip Psyc BA BSc BA (Hons)
Masters Student
Sociology Department
University of Canterbury
Supervisor: Dr Arnold Parr

To Whom It May Concern: I am a Sociology Masters student at the University of Canterbury and conducting research attempting to describe and compare the different treatment ideologies offered by drug and alcohol treatment centres and programmes in Christchurch.

In order to gain a better understanding of each centre's or treatment's ideology or underlying policies, an individual from each will be asked if they would like to be interviewed.

You a staff member at your centre or treatment facility, will be asked to discuss your or their perception of the therapy offered by your centre or treatment programme during an interview, which is envisaged to be about one hour long. However, there could be consecutive interviews if required. The interview participant will be in total control of the interview details and may cancel their participation at any stage of the interview. Their anonymity and information confidentiality will be maintained throughout the entire process.

I will phone during the next week or two to arrange an appointment with someone if they would like to be interviewed. Or if this not convenient please write or phone to discuss any queries. Dr Parr may be contacted at (03 3667001 x6185: email a.parr@soci.canterbury.ac.nz) or myself at (03 3571122: email rpk14student@canterbury.ac.nz).

Yours Sincerely

_____

R Van Kuppevelt

Appendix B

Interview Information Guideline

Unstructured Interview Topics

Each interview will be unstructured, but remain focused and retain core questions. Topics covered during the interviews are:

a) Client assessment and appropriateness

b) Treatment issues and application

c) Outcome goals

Interview subtopics are: Age, Gender, Cultural identity, Specific Needs, Treatment Models, Resources and Funding, and Competition and Co-operation.

Appendix C

Department of Sociology

Information Sheet

You are invited to participate in the Masters research project titled: "A Comparison of the Policies and Methodologies Adhered to by Drug Treatment Centres in Christchurch, Aotearoa."

The aim of this project is to describe and compare different treatment ideologies offered or available too, potential clients.

Your involvement in this project comprises an interview. The interview, time and location will be at your discretion. With your consent, and for clarity of transcription, an audio-tape will be used.

A transcript of the interview will be available if required.

In the performance of the tasks and application of the procedures there are no foreseen risks.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: The identity of the participants will not be made public. To ensure anonymity and confidentiality, the information you provide will be kept on my computer under password protection, and the audio-tapes will be deleted at the completion of the transcription.

The project is being carried out as partial requirement for a Masters thesis by myself, Richard Van Kuppevelt, under the supervision of Dr. Arnold Parr, who can be contacted at 366 7001. He will be pleased to discuss any concerns you may have about participation in the project.

The project has been reviewed by the University of Canterbury Human Ethics Committee.

Appendix D

Consent Form

A Comparison of the Policies and Methodologies
Adhered to by Drug Treatment Centres
in Christchurch, Aotearoa.

I have read and understood the description of the above-named project. On this basis I agree to participate in the project, and I consent to publication of the results of the project with the understanding that my anonymity will be preserved. I understand also that I may at any time withdraw from the project, including withdrawal of any information I have provided.

Signed..... Date.....